

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03568

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home				e. STREET ADDRESS 104 Fairview Drive			
3. NAME OF DECEASED (Type or print) Murray Henry Allen				4. DATE OF DEATH Month 3 Day 19 Year 61			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29. 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 3 Days 19		IF UNDER 1 YEAR Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Hancock Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Monroe Allen				14. MOTHER'S MAIDEN NAME Katie Long			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. Elixabeth M Allen			
17. INFORMANT 104 Fairview Drive				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arterio Sclerotic Heart Disease DUE TO (b) Senility DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE A. E. Smith M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. E. W. Tittor				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.7.61		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or country) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR Howard F. Shaw Hancock Md.				24b. REC'D BY REGISTRAR DATE MAR 7 '61		24c. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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2003 JOURNAL EXAMINER CERTIFICATE OF DEATH
11-20-03

Registered
Washington

Inventory No. 1111

Date

11-20-03
11-20-03

Inventory No. 1111

Date 11-20-03

Inventory No. 1111

Date 11-20-03

Inventory No. 1111

Date 11-20-03

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Date 11-20-03

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3594

CERTIFICATE OF DEATH

03589

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2200 Gay Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lavinia</u> Middle <u>Elizabeth</u> Last <u>Barber</u>			4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 13 1902</u>		9. AGE (In years last birthday) <u>59</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months <u>2</u> Days <u>4</u></td> <td>Hours <u></u> Min. <u></u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>2</u> Days <u>4</u>	Hours <u></u> Min. <u></u>
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>2</u> Days <u>4</u>	Hours <u></u> Min. <u></u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Charles E. Young</u>				
14. MOTHER'S MAIDEN NAME <u>Elsie Morgan</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>214 10 4291</u>			17. INFORMANT <u>Herschel H. Barber</u> Address <u>2200 Gay St. Hagerstown Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="width: 70%;"> DUE TO <u>Ventricular fibrillation</u> (b) <u>Generalized carcinomatosis of abdomen</u> DUE TO <u>Metastatic Carcinoma of uterus</u> (c) <u>Hypertensive cardiovascular disease.</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO <u>Ventricular fibrillation</u> (b) <u>Generalized carcinomatosis of abdomen</u> DUE TO <u>Metastatic Carcinoma of uterus</u> (c) <u>Hypertensive cardiovascular disease.</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO <u>Ventricular fibrillation</u> (b) <u>Generalized carcinomatosis of abdomen</u> DUE TO <u>Metastatic Carcinoma of uterus</u> (c) <u>Hypertensive cardiovascular disease.</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>March 18, 1961</u> to <u>2-9-49</u> death, 19 <u>1961</u> that (I) (we) last saw the deceased alive on <u>March 18, 1961</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Keadle</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED _____				
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>			22d. ADDRESS <u>318 North Potomac Street, Hagerstown</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 21-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>			
23d. LOCATION (City, town or county) <u>Jefferson Md.</u>		23e. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Butler</u>			ADDRESS <u>Williamport, Md.</u>				
25a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03590

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>				c. LENGTH OF STAY IN TB <u>3 1/2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH BURKETT BATMAN</u>				4. DATE OF DEATH Month Day Year <u>MARCH 22 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE -6-1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>9 16</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PAGE COUNTY VA. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY JACKSON BATMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA SHENK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>152-10-4799-F1</u>			
17. INFORMANT <u>REV. RICHARD F. BATMAN</u> Address <u>BOONSBORO MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> 19 <u>61</u> , to <u>March 22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> 19 <u>61</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Heelan</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>G. W. Heelan</u>	
22d. ADDRESS <u>Boonsboro Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 25 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAUMS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PAGE CO. VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>Boonsboro MD.</u>				25a. REC'D BY REGISTRAR <u>MAR 24 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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03591

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
c. LENGTH OF STAY IN 1b 41 years		d. STREET ADDRESS 11 W. Water St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 W. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Myrtle Last Beard		4. DATE OF DEATH Month March Day 20 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1867
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry J. Poffenberger		14. MOTHER'S MAIDEN NAME Anna Rudisill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Anna Stem, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 Yrs.			INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/5 1955 to 3/20 1961 , that (I) (we) last saw the deceased alive on 3/19 1961 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 3/20/61	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-22-61	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	23d. LOCATION (City, town, or county) (State) Smithsburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR DATE MAR 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hess			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Countersigned by E.W. Ditto III M.D. Med. Examiner

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3597											
CERTIFICATE OF DEATH											
03592											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>27 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1131 Hamilton Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Elmer</u> Last <u>Brenner</u>						4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1895</u>		9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Brenner</u>						14. MOTHER'S MAIDEN NAME <u>Emma Ridenour</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>219-20-1895</u>		17. INFORMANT <u>Mary C. Young</u> Address <u>1131 Hamilton Blvd. Hagerstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>PULMONARY EMPHYSEMA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>45 MINUTES</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 31</u> , 19 <u>61</u> , to <u>MARCH 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MARCH 31</u> , 19 <u>61</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>E. R. Laddizabal</u>				22b. DATE SIGNED <u>APRIL 1, 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>E. R. Laddizabal, Md</u>			
22d. ADDRESS <u> </u>				22e. ADDRESS <u> </u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) <u>Hagerstown, Md.</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

25

2000

76-3731-2-1500

1. *Chlorophyll a* (Chl *a*)

296 297 298 299 300

U.S. National Archives, RG 226, Entry 100-37015

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

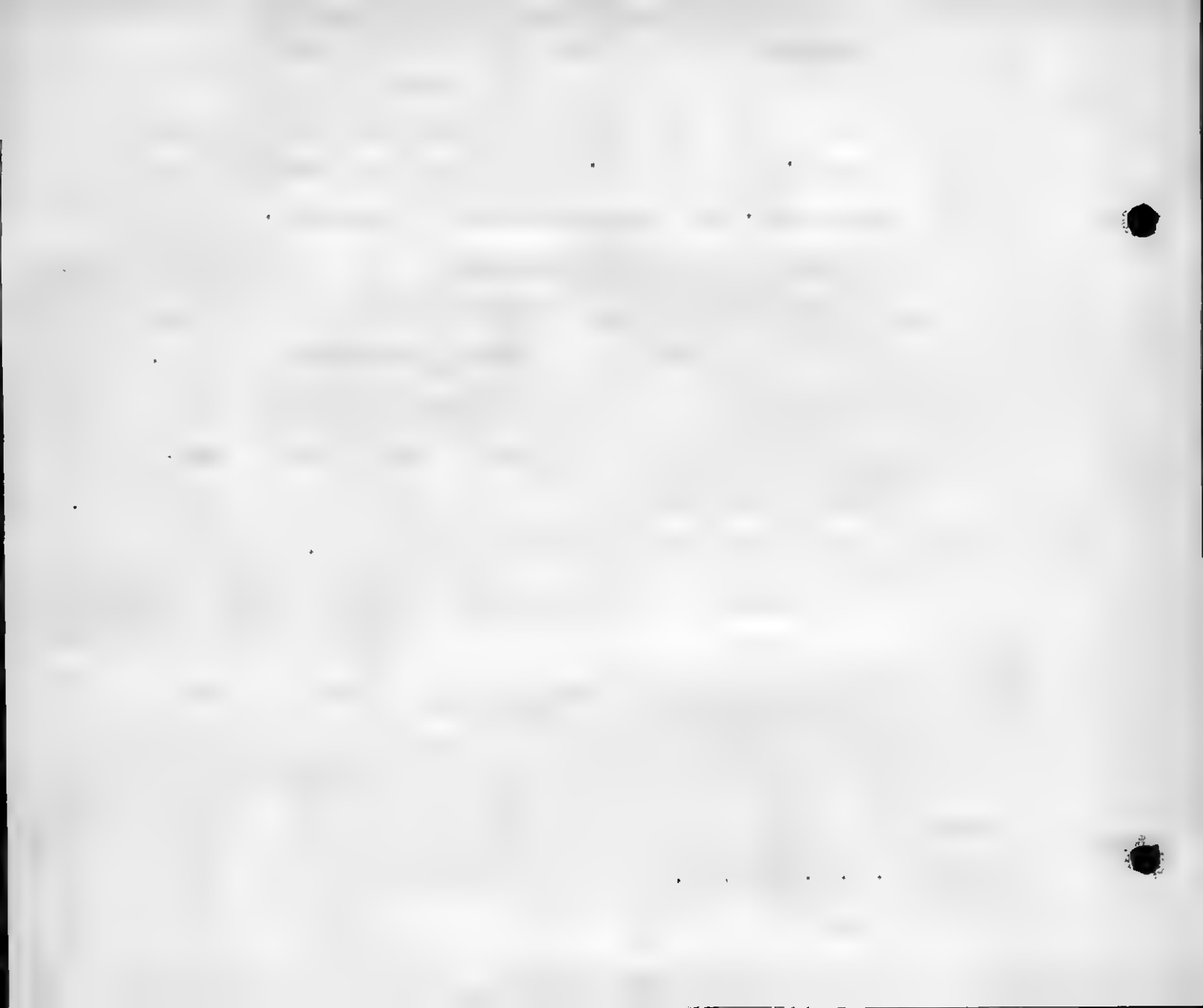
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03592

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>				c. LENGTH OF STAY IN 1b <u>12yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>121 1/2 Clarkson, Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Frances</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 26 1949 12</u> yrs.	
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Lawerance Brown</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Stribling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Virginia Brown 405 Sumans Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>3 25.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mentally Retarded from Age Of 2 Years.</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Several Days.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-13-61</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr.</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Kneass</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3599

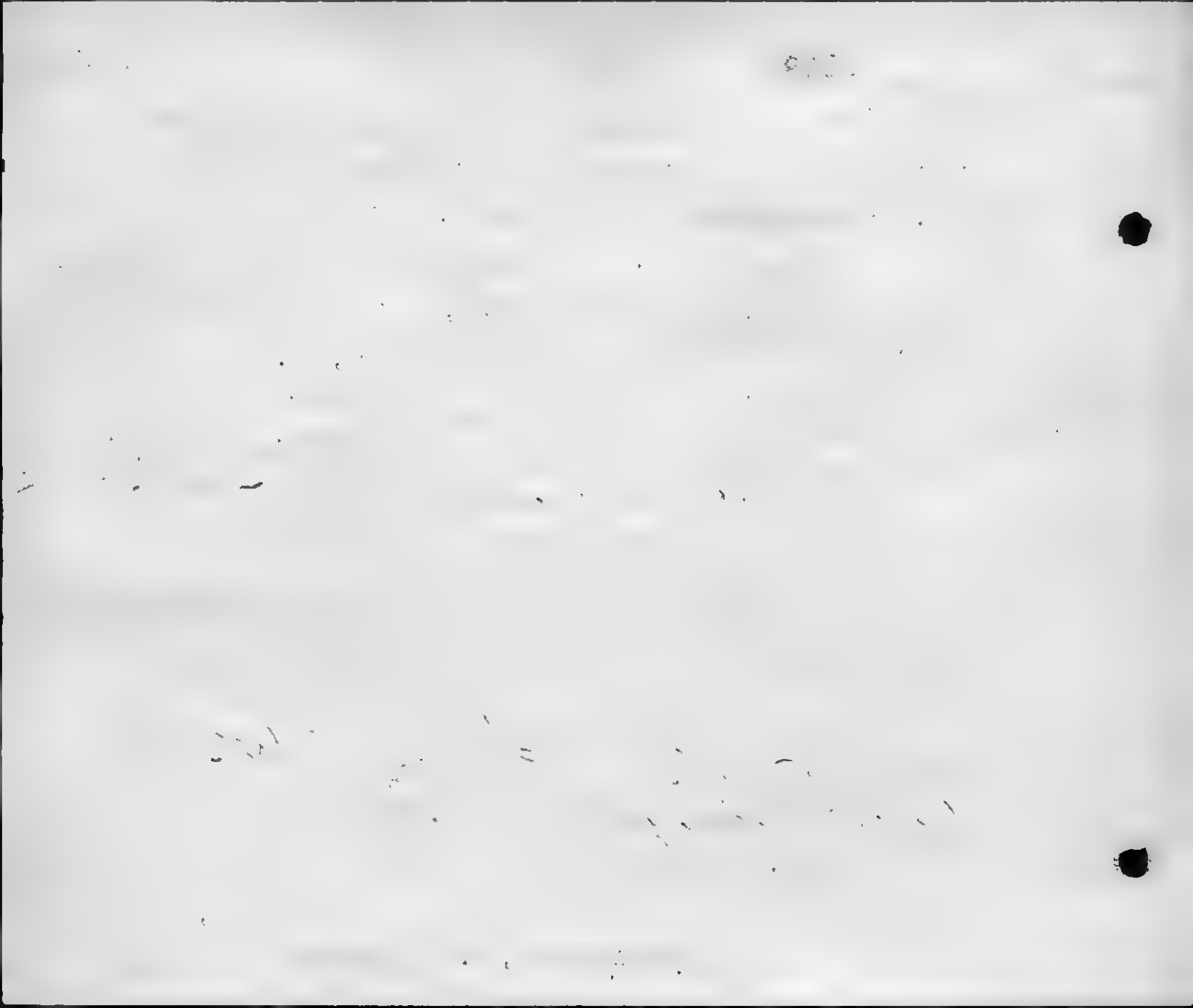
CERTIFICATE OF DEATH

03594

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 106 S. Artizan Street		d. STREET ADDRESS 106 S. Artizan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Noland L. Brown		4. DATE OF DEATH Month Day Year March 15 1961			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1873	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days 9 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Town of Williamsport		11. BIRTHPLACE (County & State, or foreign country) Williamsport, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Brown		14. MOTHER'S MAIDEN NAME Celia Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 09 9257		17. INFORMANT Address Annie Broudas 106 S. Artizan St. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 3/15/61, to 3/15/61, 1961, that (I) (we) last saw the deceased alive on 3/15/61, and that death occurred at 12:00 PM, from the causes and on the date stated above.					
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 3/15/61		22c. PHYSICIAN'S NAME (Type) Ralph F. Young	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 3/19/61		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
23d. LOCATION (City, town or county) Williamsport, Maryland		23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE Albert L. Leaf			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

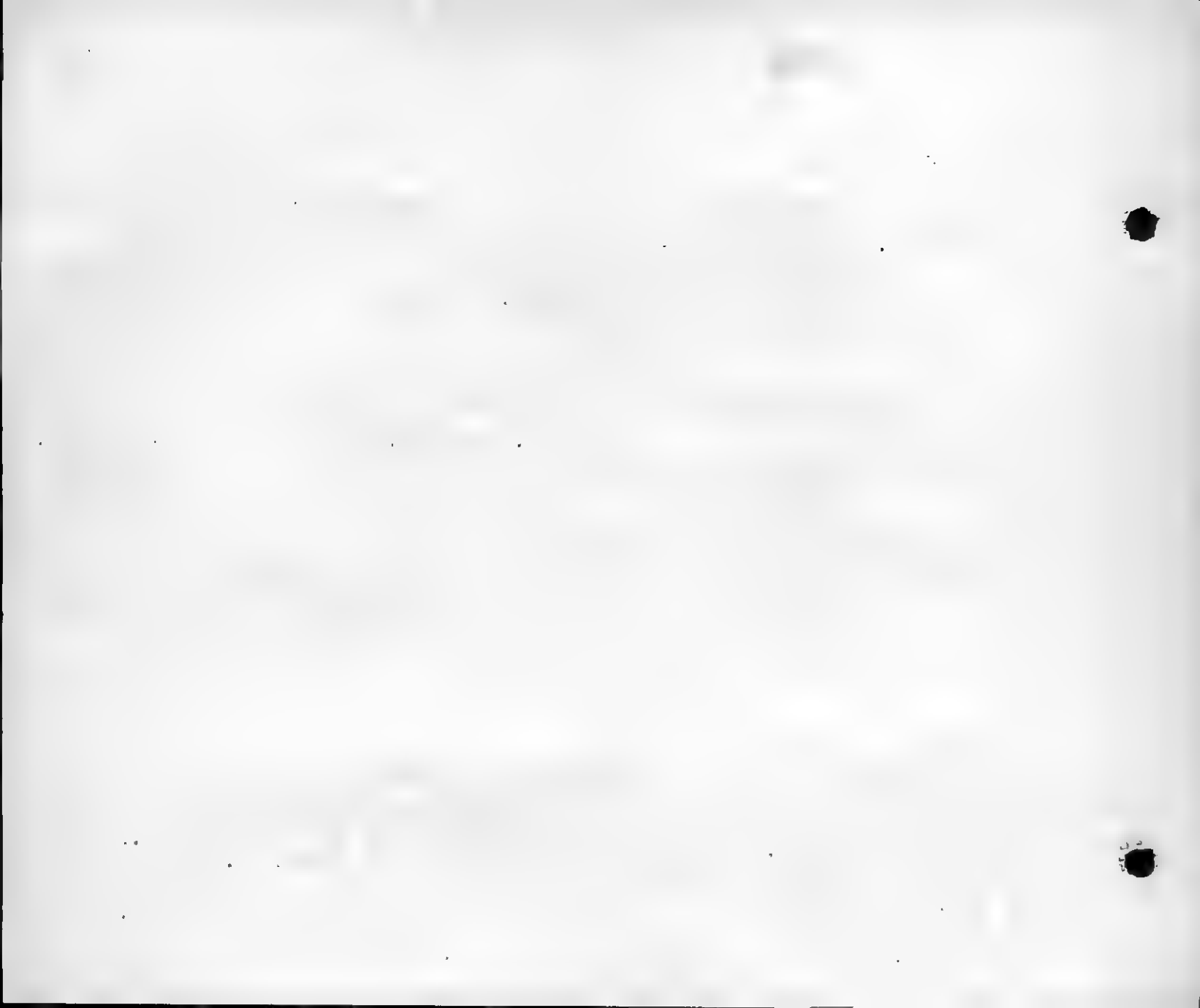
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3600

CERTIFICATE OF DEATH

03595

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 years		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 3 Wynnwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Charles Franklin Carbaugh		4 DATE OF DEATH Month Day Year March 6 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Broadfording, Md.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME George Carbaugh		14. MOTHER'S MAIDEN NAME Ida Bloyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Maude I. Carbaugh Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertensive cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH 3 days - Unknown 30 yrs(?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-26, 1957 to 3-6, 1961 , that (I) (we) last saw the deceased alive on 3-6 - 1961 , and that death occurred at 7:05 P from the causes and on the date stated above					
22a. SIGNATURE John H. Hornbaker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3:7:61	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker		22d. ADDRESS 154 West Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City, town, or county) (State) Hagerstown, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

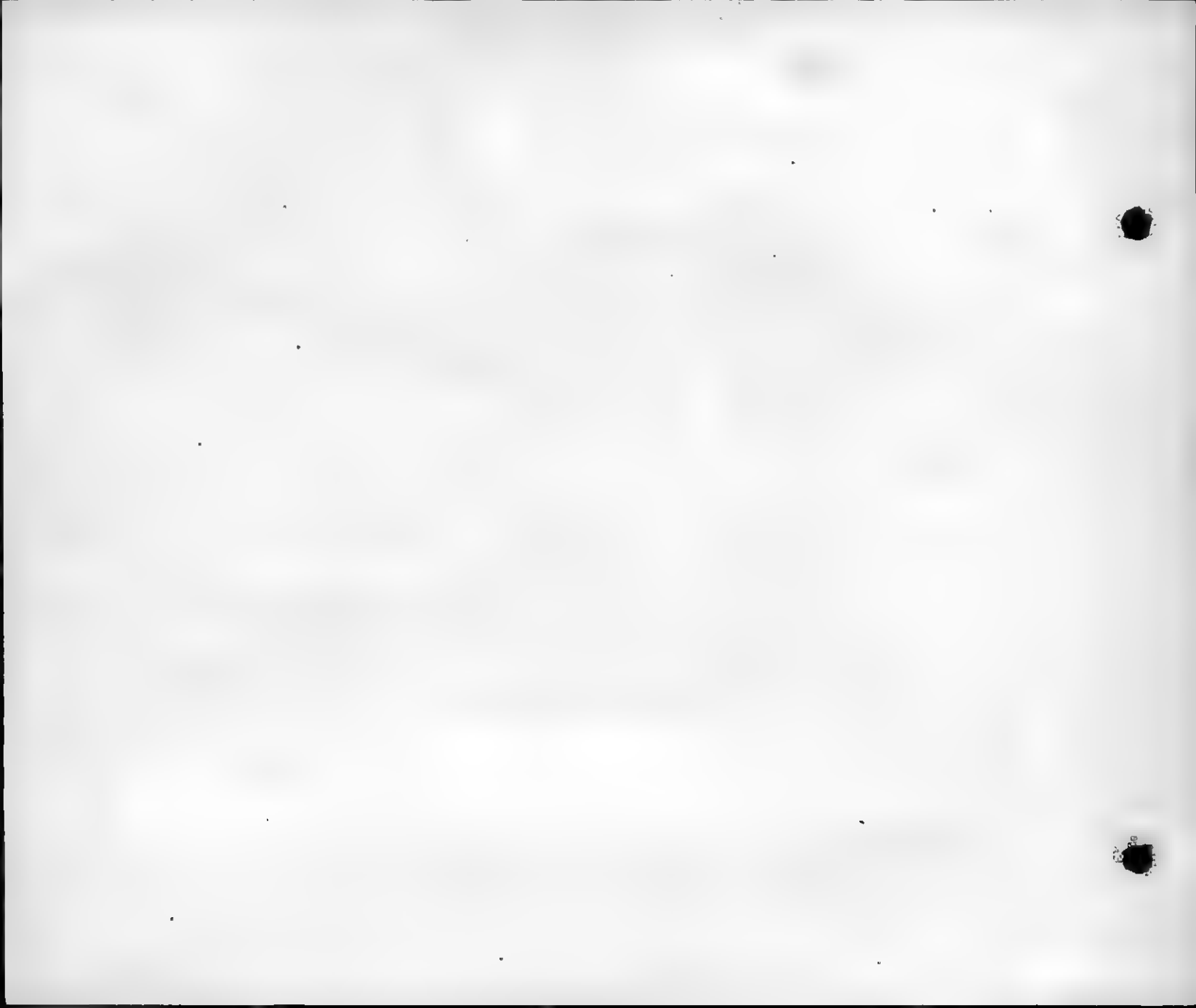


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3601

03596

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.			c. LENGTH OF STAY IN lb weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Md. State Hospital				d. STREET ADDRESS 358 Bedford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy Virginia Carder <i>Dorothy Virginia Carder</i>				4. DATE OF DEATH Month March Day 9 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1924	
9. AGE (In years last birthday) yrs. 36		10. FINDER 1 YEAR Months 36 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Richard Boyden				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Glen Carder, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 21X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pelvic metastasis DUE TO (c) carcinoma of cervix						INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos. 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960 to March 9, 1961 , that (I) (we) last saw the deceased alive on March 9, 1961 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramon				22b. ADDRESS Western Md. State Hospital, Hagerstown, Md.		22c. PHYSICIAN'S NAME (Type) Victor L. Ramon, M.D.	
23a. BIRTHAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3-12-1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAR 13 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3602

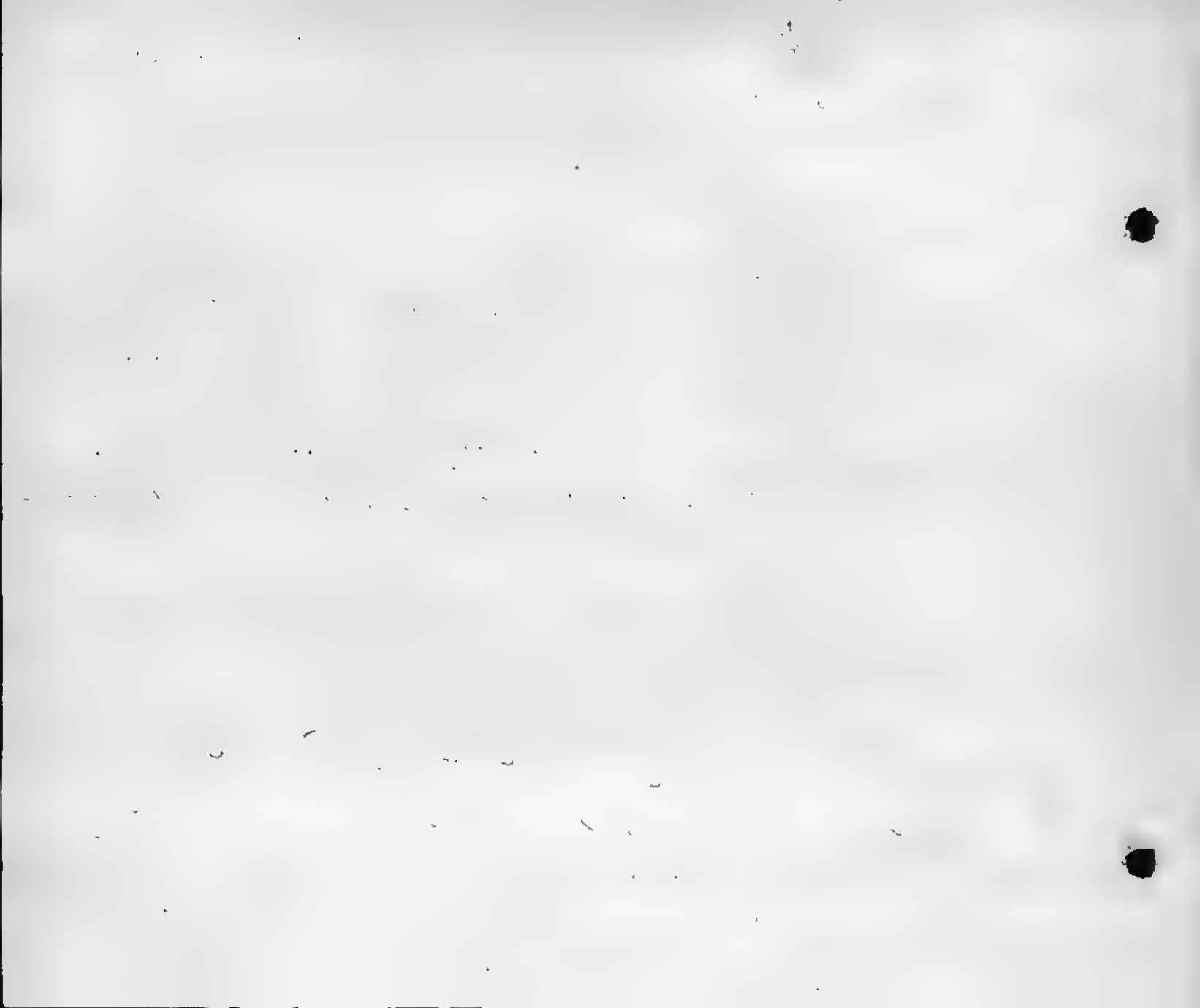
CERTIFICATE OF DEATH

03597

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> c. LENGTH OF STAY IN 1b <u>24 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Downsville Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> d. STREET ADDRESS <u>Downsville Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Stella May Dolly Cline</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 61</u>		5. SEX <u>Female</u>									
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct, 19 1896</u>									
9. AGE (In years last birthday) <u>64</u> yrs. <table border="1" style="display: inline-table; font-size: 0.8em;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>5</u></td> <td><u>16</u></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.	<u>5</u>	<u>16</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
Months	Days	Hours	Min.										
<u>5</u>	<u>16</u>												
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Luke Wolford</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Renner</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Harry Cline Sr. Downsville Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ac. myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____													
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____									
20f. (City or town) _____		20g. (County) _____		20h. (State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>3/26/61</u>, 19<u>61</u>, to <u>3/27/61</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>3/27/61</u>, and that death occurred at <u>4 AM</u>, from the causes and on the date stated above.													
22a. SIGNATURE <u>Ralph Young M.D.</u>		22b. DATE SIGNED <u>3/27/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Ralph Young M.D.</u>									
22d. ADDRESS <u>Albert L. Leaf Williamsport, Md</u>		22e. REC'D BY REGISTRAR DATE <u>MAR 30 '61</u>		22f. REGISTRAR'S SIGNATURE <u>Albert L. Leaf</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>									
23d. LOCATION (City, town or county) <u>Williamsport Md.</u>		23e. (State) _____		23f. (County) _____									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The fee 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



3603

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03598

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>329 Valley Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Gearhart Clugston</u>		4. DATE OF DEATH Month Day Year <u>March 1, 1961</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Co</u>	
13. FATHER'S NAME <u>David Clugston</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Gearhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-07-8279</u>	
17. INFORMANT <u>Charles A. Clugston</u>		18. ADDRESS <u>329 Valley Rd Hagerstown MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration of stomach contents</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebro-vascular accident</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Hemorrhagic cystitis ② chronic pyelonephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 27, 1961</u> to <u>March 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1961</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u>		22b. ADDRESS <u>Victor L. Ramos, M.D.</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munich</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>			

22b. DATE SIGNED
March 1, 1961



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

113599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>03</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>				d. STREET ADDRESS <u>111 Bloom's Alley</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Solia</u> Middle <u>Mae</u> Last <u>Colmes</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1873</u>	
				9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wise (?)</u>				14. MOTHER'S MAIDEN NAME <u>Wise (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>7170</u> DUE TO <u>Burns of Legs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cystic Disease of Liver</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>1 month</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Probable Burn from Coal Stove at home</u>					
20c. TIME OF INJURY Hour <u>3</u> o. m. <u>22</u> p. m. <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Dittmann</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Edward W. Dittmann, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, 12. REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Mar 21 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B Watson Jr.</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

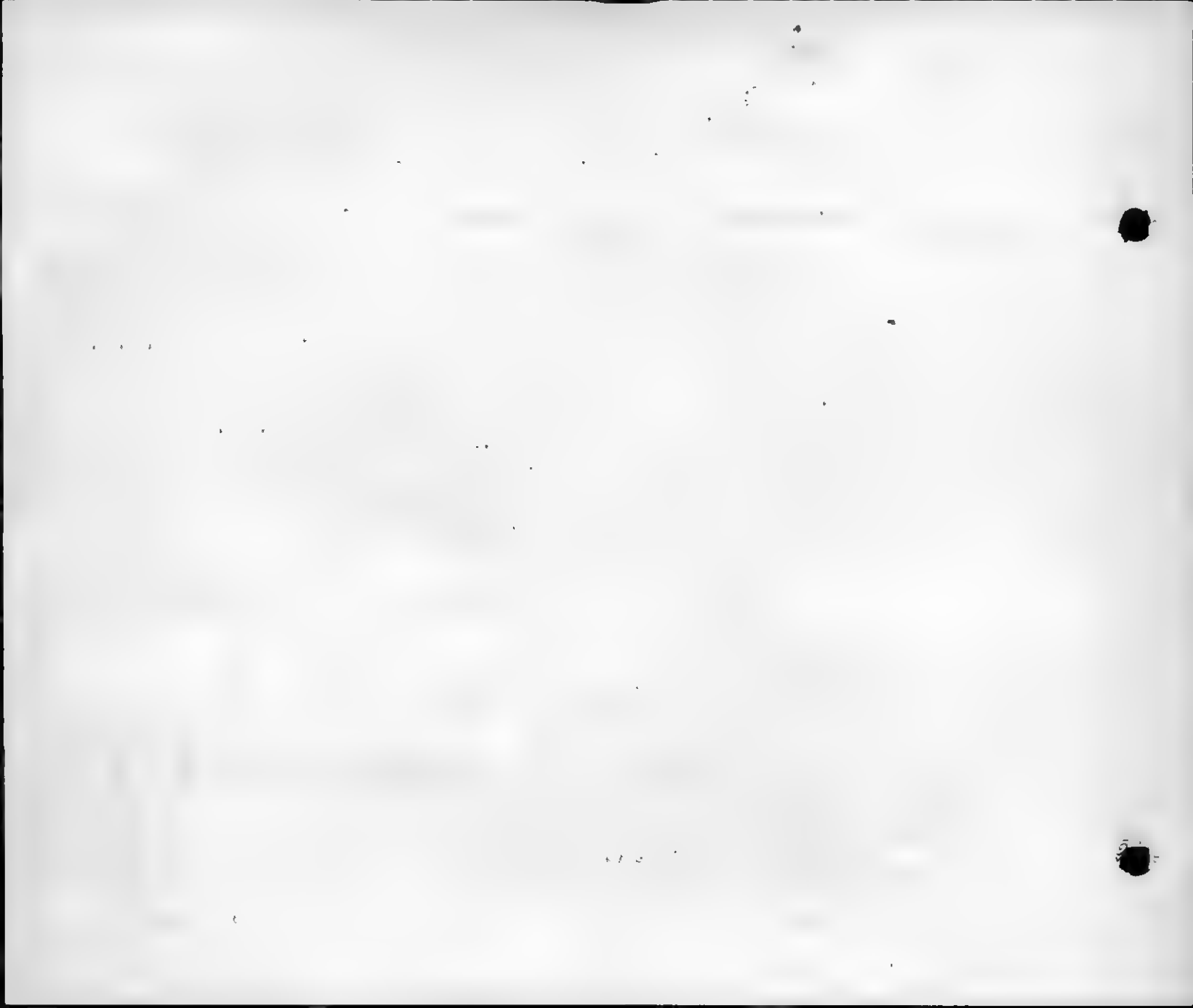
3603

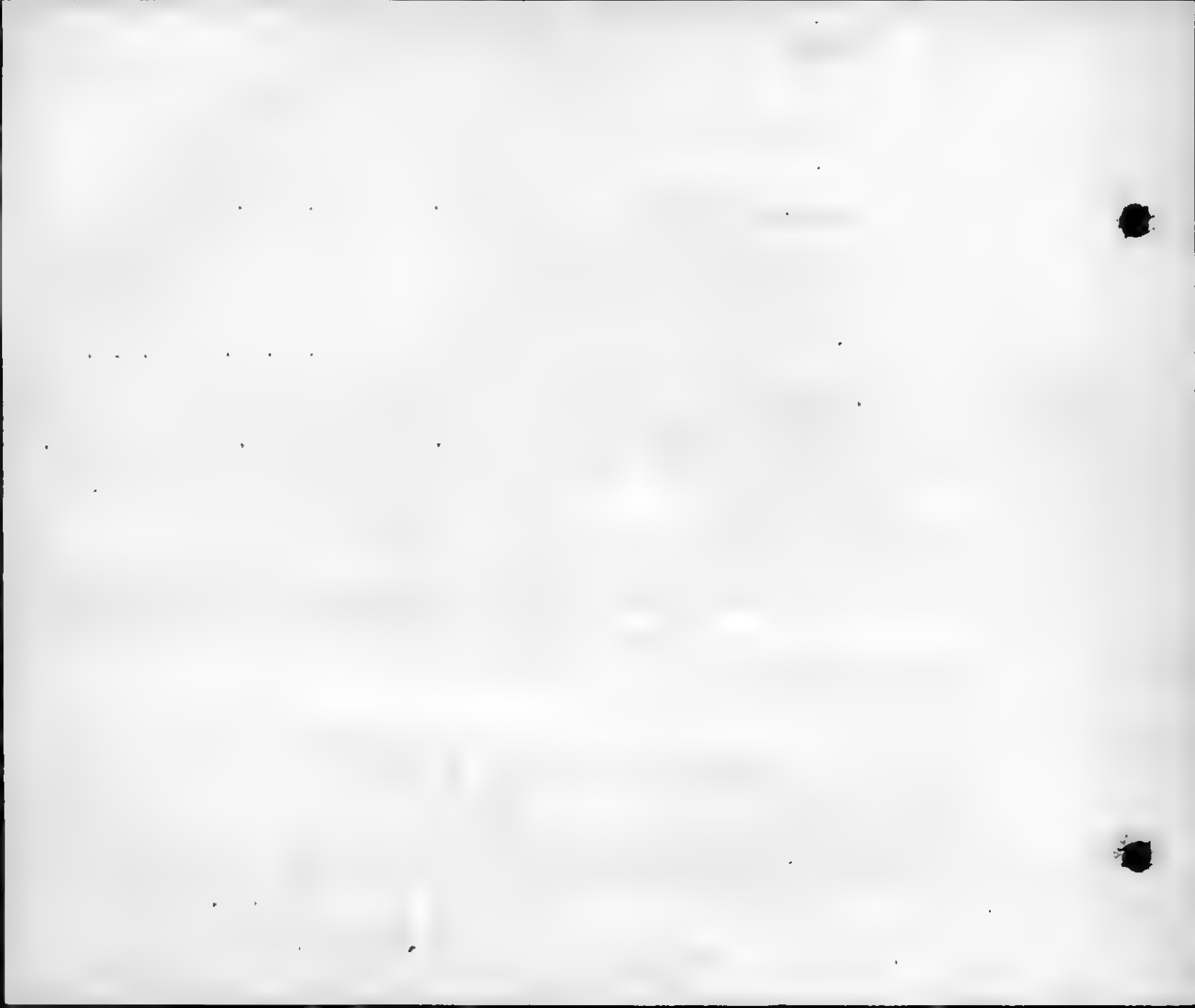
3603

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03600

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv. Home</u>				e. STREET ADDRESS <u>Intervale Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Jacob Corwell</u>				4. DATE OF DEATH Month Day Year <u>March 20 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1873</u>	9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Caledonia, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Corwell</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-11-11-11</u>		17. INFORMANT <u>Hagerstown, Wash. Co., Maryland</u> <u>Mrs. Aletta Partlow 980 Jefferson Blvd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> 4-11-11-11 DUE TO (b) <u>Arterial Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1961</u> to <u>Mar 20, 1961</u> that (I) (we) last saw the deceased alive on <u>Mar 20, 1961</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>David R. Brewer</u> M.D.				22b. DATE SIGNED <u>3/22/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>				22d. ADDRESS <u>Clear Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>James S. Hines</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

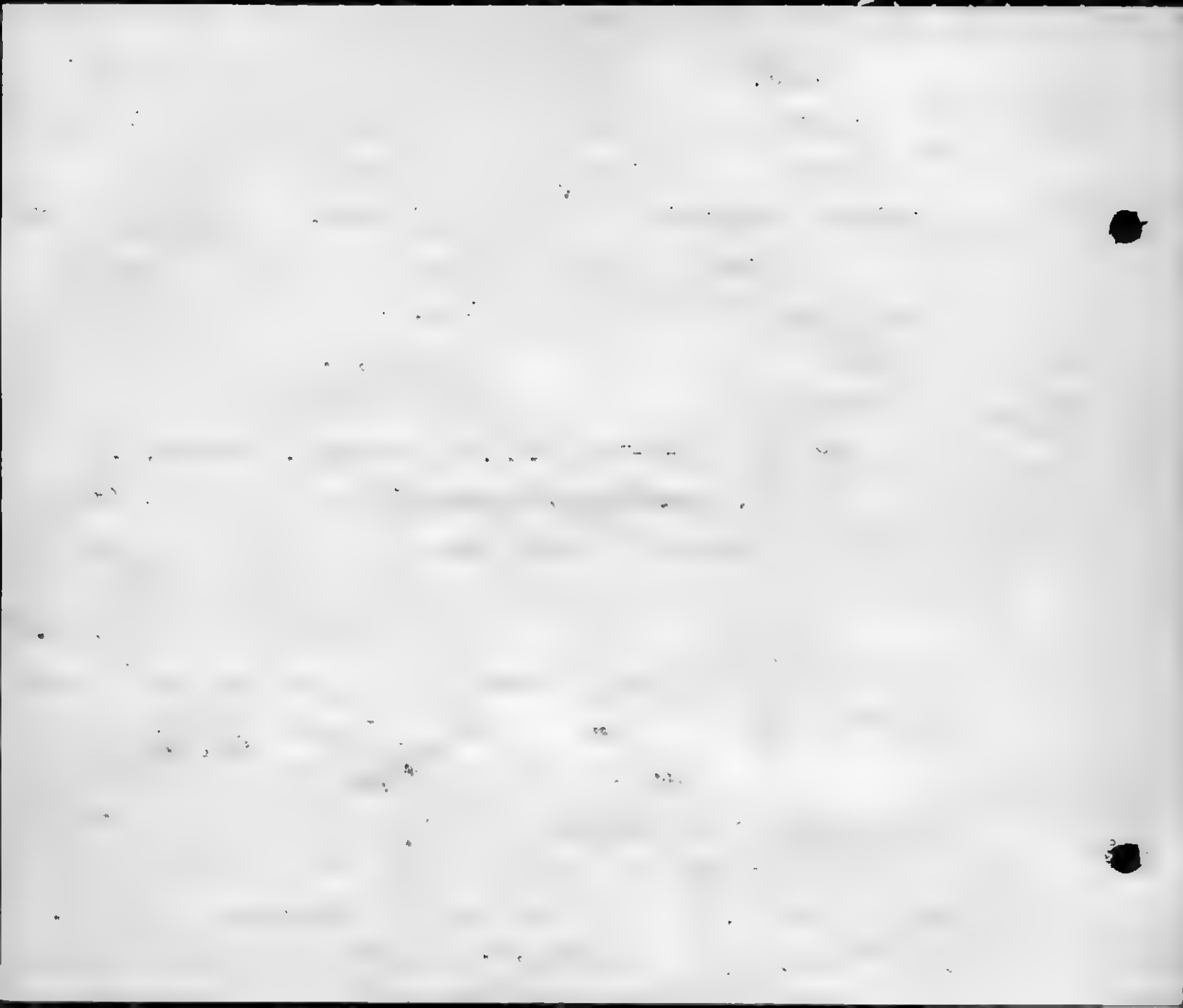
3607

CERTIFICATE OF DEATH

03602

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>24 High St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Oscar</u> Last <u>Derr</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1916</u>
9. AGE (In years last birthday) <u>44</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Oscar Derr</u>		14. MOTHER'S MAIDEN NAME <u>Belva Gay Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW II (2)</u>		16. SOCIAL SECURITY NO. <u>214-09-7258</u>	
17. INFORMANT <u>Mr. C.O. Derr</u>		Address <u>24 High St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). a. DEATH WAS CAUSED BY: M.D. DATE CAUSE (a) <u>Ingestion of Prestone = Accidental</u> b. <u>Acute Alcoholism</u> c. <u>2 days +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>32 1/2 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally drank 1 pt. of Prestone thinking it contained alcohol</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5:30</u> <u>3 9 61</u> p.m. <u>1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hagerstown Washington Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/9 1961</u> to <u>3/10 1961</u> , that (I) (we) last saw the deceased alive on <u>3/10 1961</u> , and that death occurred at <u>5:35 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank F. Shupp</u> M.D.		22b. DATE SIGNED <u>3/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank F. Shupp</u>		22d. ADDRESS <u>109 1/2 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 13, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

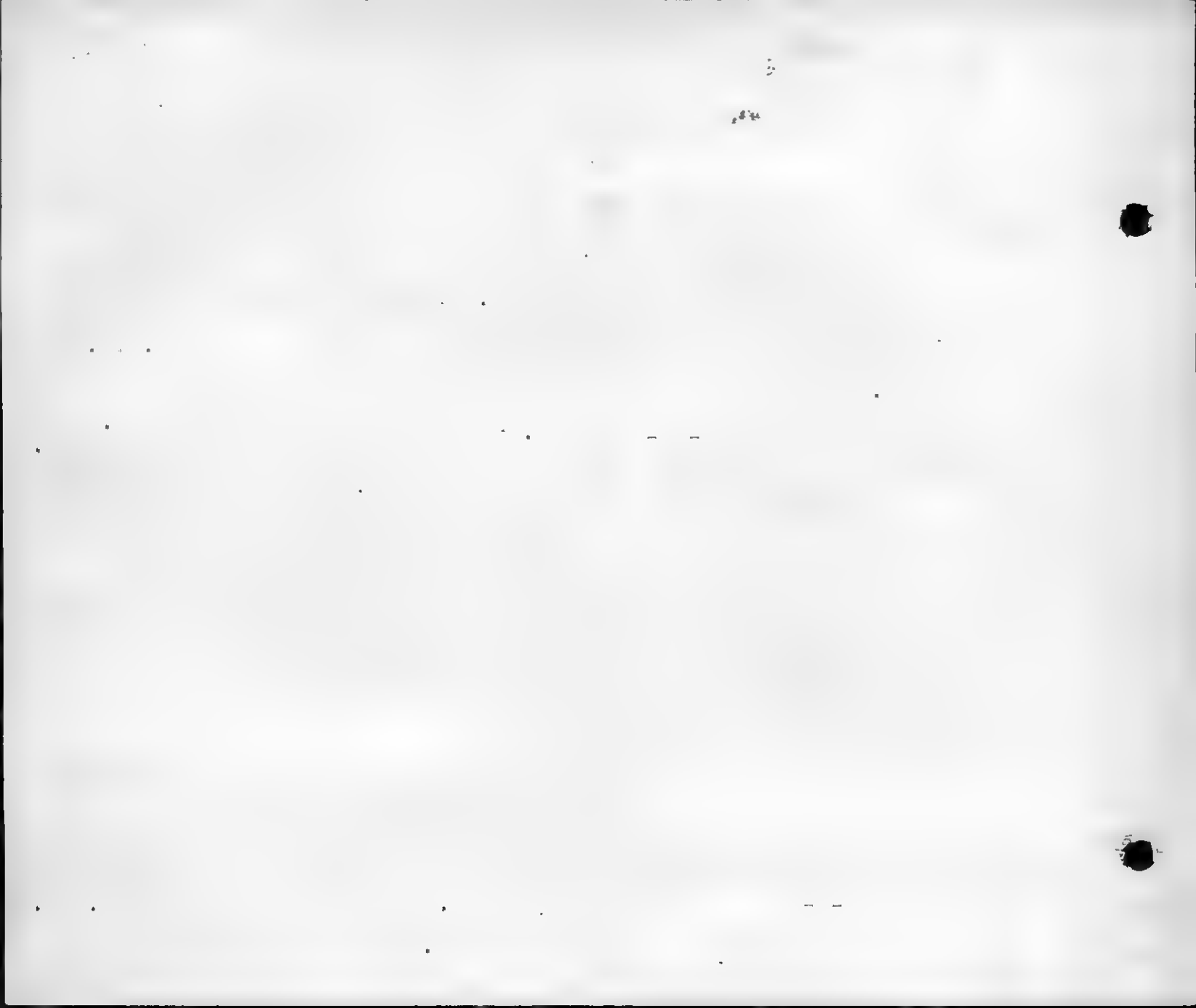
VR AIS (4)
15M 9/59

3608

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03603

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 10 x 2			
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last EBY				4. DATE OF DEATH Month MARCH Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1881		9. AGE (In years, old birthday) yrs 80	10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Shields				14. MOTHER'S MAIDEN NAME Margaret Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-38-0734		17. INFORMANT Mrs. Frank Cummings Address 9011 Eton Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BLADDER DUE TO (c) 17 MONTHS						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from DEC 10, 1960 , to MARCH 5, 1961 , that (I) (we) last saw the deceased alive on MARCH 5, 1961 , and that death occurred at 11:30 PM , from the causes and on the date stated above							
22a. SIGNATURE Antonio H. Pellegrini				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTONIO H. PELLEGRINI				22d. ADDRESS 1501 PENNSYLVANIA AVE HAGERSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-61		23c. NAME OF CEMETERY OR CREMATORY Sabillasville Cem.		23d. LOCATION (City, town, or county) (State) Sabillasville Fred. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Brager				ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR DATE MAR 10 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3609 CERTIFICATE OF DEATH

03604

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>9 Hrs</u>				d. STREET ADDRESS <u>1032 So Colonial Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMER MARGARET ELGIN</u>				4. DATE OF DEATH Month Day Year <u>March 11 1961 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 16 1895</u>	
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Laugansville Wash Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wolfensberger</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Cameron E. Elgin 1032 So Colonial Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost, (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>year</u> <u>3 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 PM</u> <u>1961</u> to <u>11 PM</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>10 Mar</u> <u>1961</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Eldon H. Hockley</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Eldon H. Hockley</u>				22d. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Id</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2610

03605

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA</u>	
c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>		d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>W.</u> Last <u>FAULDERS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-5-1883</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>1</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRM.</u>	
11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SOLOMAN FAULDERS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA COX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROGER FAULDERS</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 7-10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>duodenal ulcer - hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>March 10 1961</u> that (I) (we) last saw the deceased alive on <u>March 10 1961</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Harrison MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATON, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 13. 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. East</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 15 '61</u>	
ADDRESS <u>BOONSBORO MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	



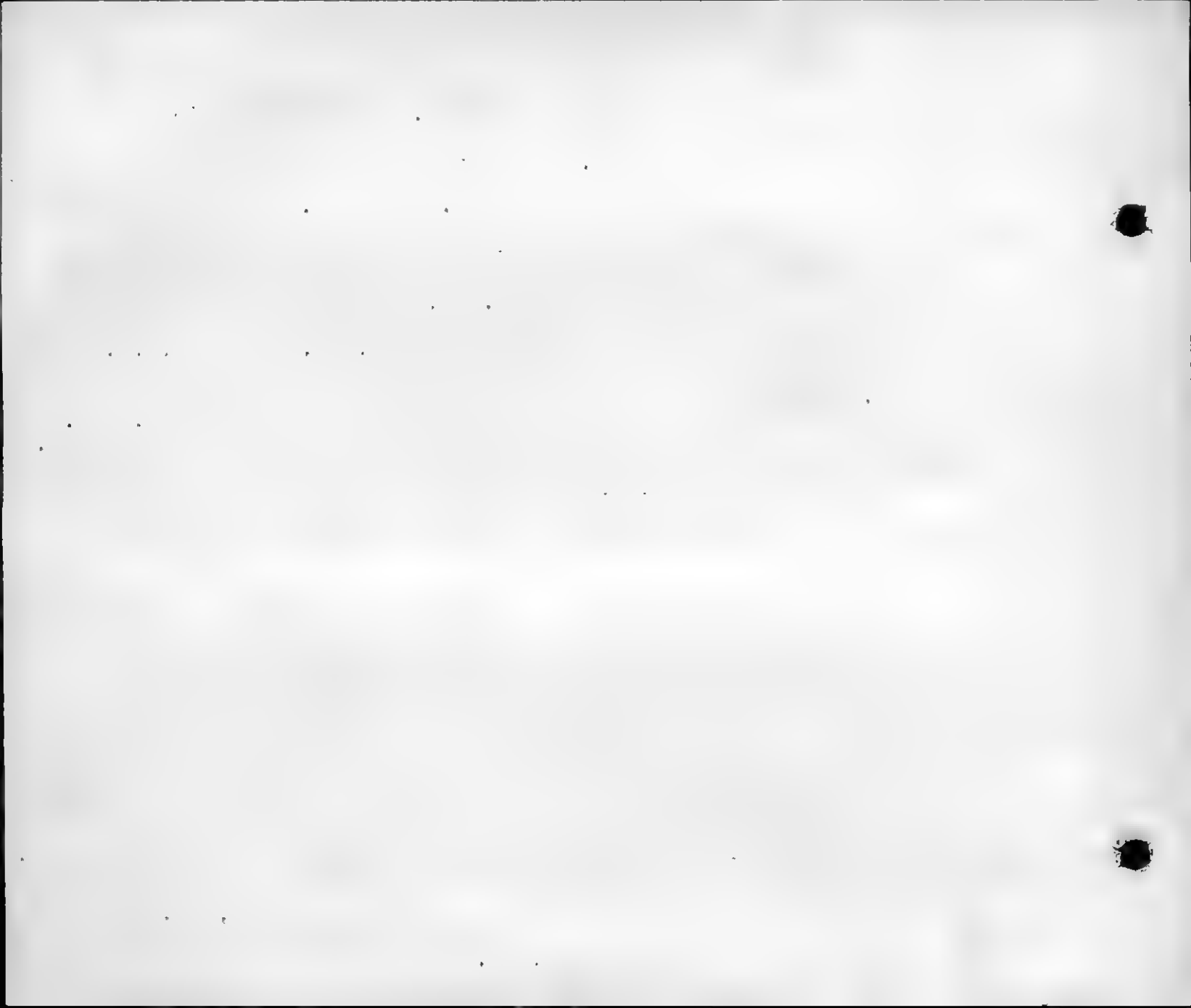
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3611

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03606

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg.	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Long Foster		4. DATE OF DEATH Month Day Year March 25, 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1876
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Knobsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Adam Long		14. MOTHER'S MAIDEN NAME Jane Glunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address 229 S. 6th. St. Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/25/61 12 to 3/25/61 19, that (I) (we) last saw the deceased alive on 3/25/61 19, and that death occurred at M, from the causes and on the date stated above			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 North Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Knobsville		23d. LOCATION (City, town, or county) (State) Knobsville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Barber		ADDRESS Chambersburg, Pa.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	
DATE MAR 29 '61			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3612

CERTIFICATE OF DEATH

03657

1. PLACE OF DEATH
a. COUNTY Washington **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor

2. USUAL RESIDENCE (Where deceased lived, if Institutions: Residence before death)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS Route 66 36 Broadway

3. NAME OF DECEASED (Type or print) Cornelia Orrick Funkhouser
First Middle Last
4. DATE OF DEATH 3 3 19 61
Month Day Year

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-1-90 1890
Last First Middle Initial
9. AGE (In years last birthday) 71 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.
11. BIRTHPLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lewis J. Orrick
14. MOTHER'S MAIDEN NAME Annie Hieronimus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. Lewis Funkhouser Hagerstown, Md.
17. INFORMANT Lewis Funkhouser Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of liver (primary?)
155.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) 155.0
(a), stating the underlying cause last. DUE TO (c) Arteriosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ☐ YES ☒ NO
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Mar 3, 1961
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Md.
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 3, 1961 **that (I) (we) last saw the deceased alive on** Mar 3, 1961, **and that death occurred at** 11:32 P.M. **from the causes and on the date stated above.**

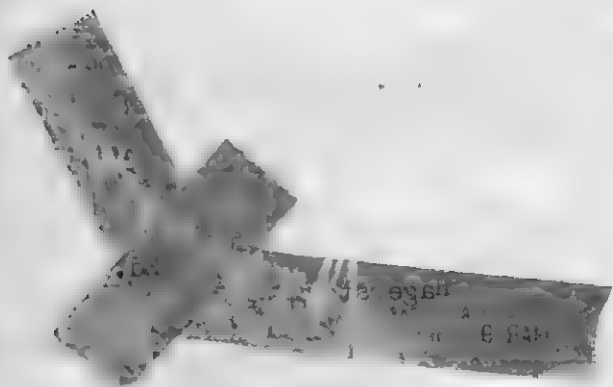
22a. SIGNATURE R. S. Stauffer **22b. PHYSICIAN'S NAME (Type)** R. S. STAUFFER
M.D. **22c. ADDRESS** Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** 3/6/1961 **23c. NAME OF CEMETERY OR CREMATORY** Rose Hill Cemetery
23d. LOCATION (City, town or county) Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Meyer **25a. REC'D BY REGISTRAR** MAR 9 '61 **25b. REGISTRAR'S SIGNATURE** Caroline L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



3613

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

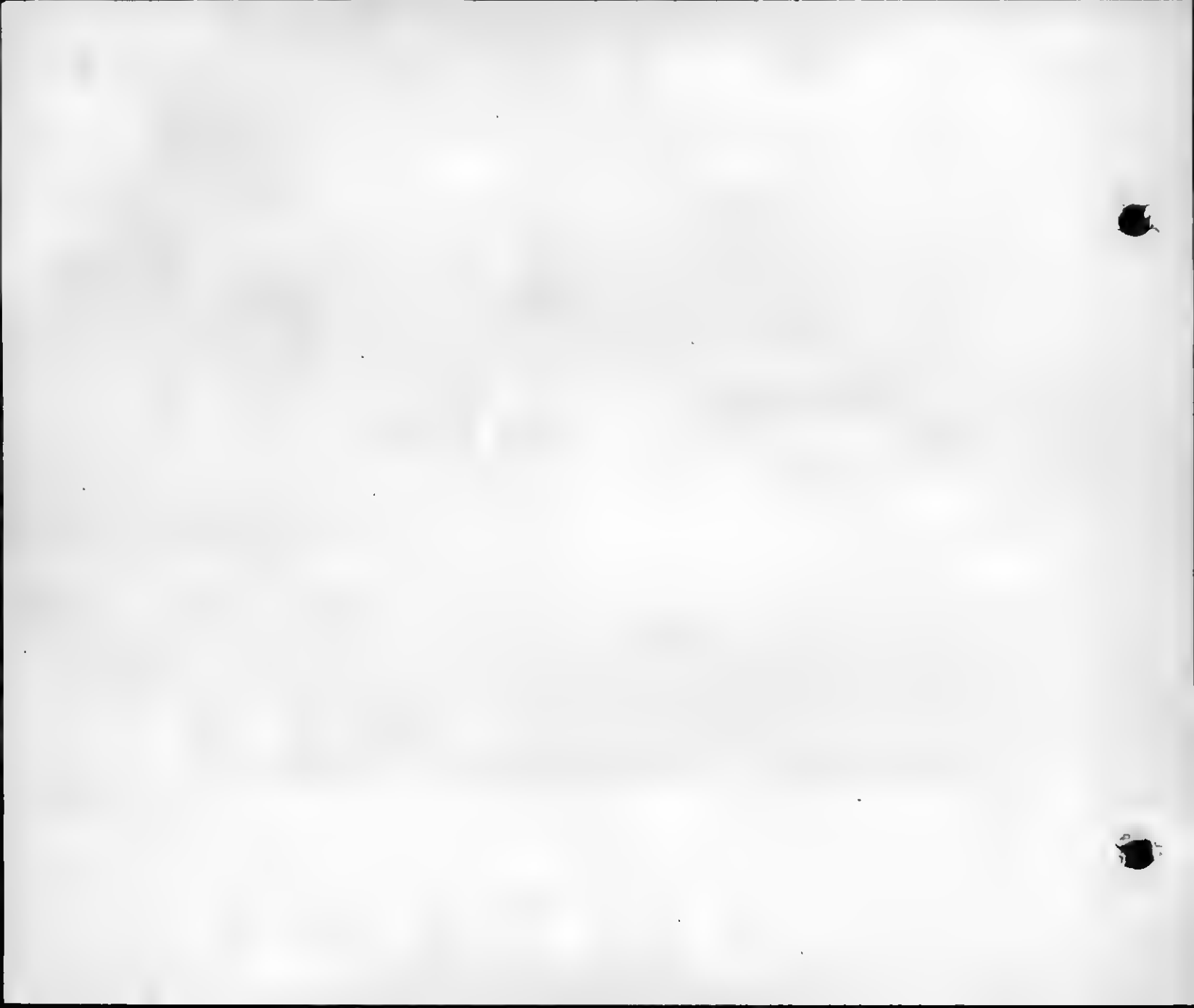
03610

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>ONE YEAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD. R.I.</u>		d. STREET ADDRESS <u>1 KEEDYSVILLE MD. R.I.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN STANLEY GREEN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 17 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27 1922</u>
9. AGE (In years last birthday) <u>38</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	11. BIRTHPLACE (State or foreign country) <u>MT. AETNA WASH. CO. MD. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ADAM GREEN</u>	
14. MOTHER'S MAIDEN NAME <u>LULA SAUNDERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-16-4029</u>		17. INFORMANT <u>ADAM GREEN KEEDYSVILLE MD. R.I.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Fever Heart</u> 4-1-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 16 1961</u> to <u>March 17 1961</u> , that (I) (we) last saw the deceased alive on <u>March 1 1961</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. W. W. W.</u>		22b. DATE SIGNED <u>3/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. W. W.</u>		22d. ADDRESS <u>Boonsboro, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 20 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>		25. REC'D BY REGISTRAR <u>MAR 21 '61</u>	
25a. ADDRESS <u>Boonsboro MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3614

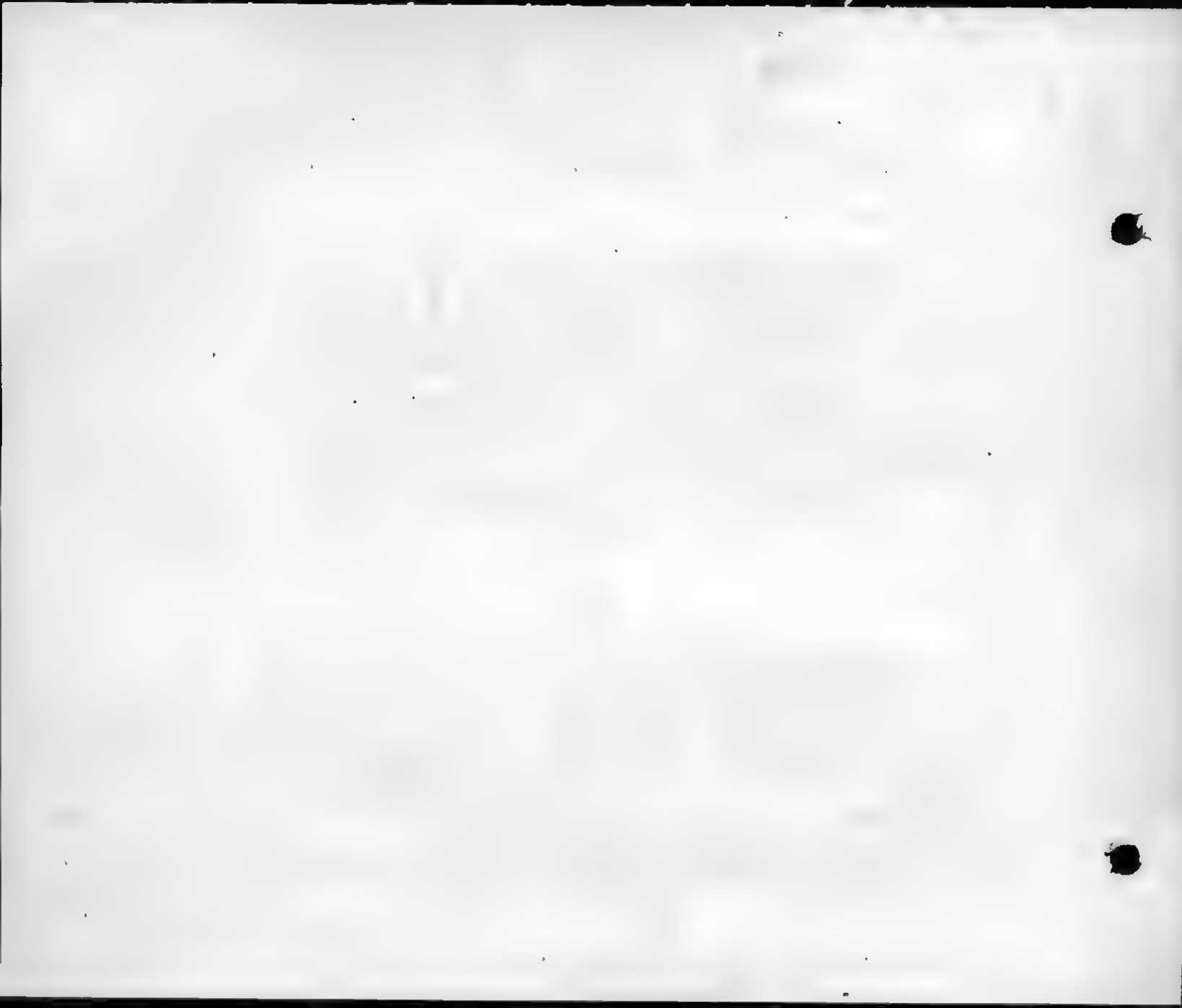
CERTIFICATE OF DEATH

Dr Harrison & Keagle

03608

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>22 Hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Unnamed baby of Earl Griffith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27 1961</u>
9. AGE (In years last birthday) yrs <u>32</u>		10. IF UNDER 1 YEAR Months <u>32</u> Days <u>22</u> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret J. Wynkoop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Earl Griffith Sharpsburg R # 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Conjugal atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>22 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>March 26, 1961</u> to <u>March 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 27, 1961</u> , and that death occurred at <u>3:55</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Harrison MD</u>		22b. DATE SIGNED <u>3/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr Paul Harrison</u>		22d. ADDRESS <u>318 No Potomac St Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew E. Coffin</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
24a. ADDRESS <u>Hagerstown Md.</u>		24c. REC'D BY REGISTRAR DATE <u>MAR 29 '61</u>	

2091275.XV3



1 FOR STATE HEALTH DEPT.

TO DEFEND: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please call the State Health Department and obtain a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

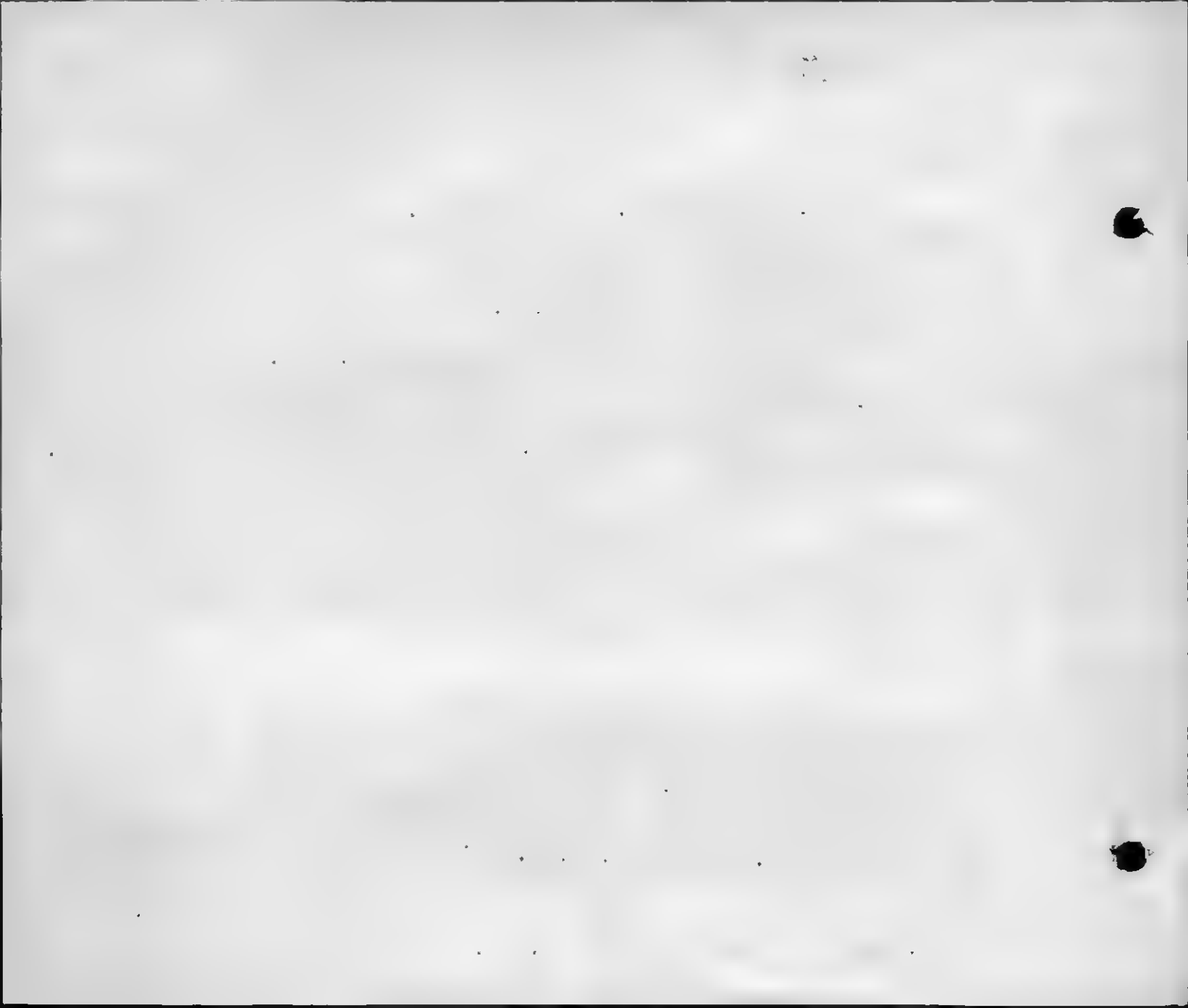
VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3613 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03611

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 66 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 278 S. Prospect St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 278 S. Prospect St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Frederick Griffith		4. DATE OF DEATH March 24 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1894
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer self employed window		12. KIND OF BUSINESS OR INDUSTRY Washing	
13. BIRTHPLACE (State or foreign country) Hagerstown, Md.		14. CITIZEN OF WHAT COUNTRY?	
15. FATHER'S NAME John H. Griffith		16. MOTHER'S MAIDEN NAME Catherine Burgur	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		18. SOCIAL SECURITY NO. 220-09-9090	
19. INFORMANT Mrs. Lula A. Griffith		20. ADDRESS Washington D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia - due to aspiration of vomitus.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) of vomitus.			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerosis - Severe			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III		DATE SIGNED 3/25/61	
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.		ADDRESS (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-27-61	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or country) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR Scott F. Minnich & Son		24. REC'D BY REGISTRAR DATE MAR 28 '61	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3616

03609

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESSIE Middle LEE Last GRIMM		4. DATE OF DEATH Month March Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Dargan, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher Columbus Hanes		14. MOTHER'S MAIDEN NAME Margaret Katherine Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Edwin Keller		Address RFD# 1, Harpers Ferry, West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Several years		INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Edwin Keller attended the deceased from July 1958 to March 26, 1961 , that (I) last saw the deceased alive on March 26, 1961 , and that death occurred at 6:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Edwin Keller M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HARRY BIZEMORE JR		22d. ADDRESS Shepherdstown, W. Va.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		23d. LOCATION (City, town or county) (State) Samples Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Donald Eakles		25a. REC'D BY REGISTRAR West Va.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		DATE APR 3 '61	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and the funeral director be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

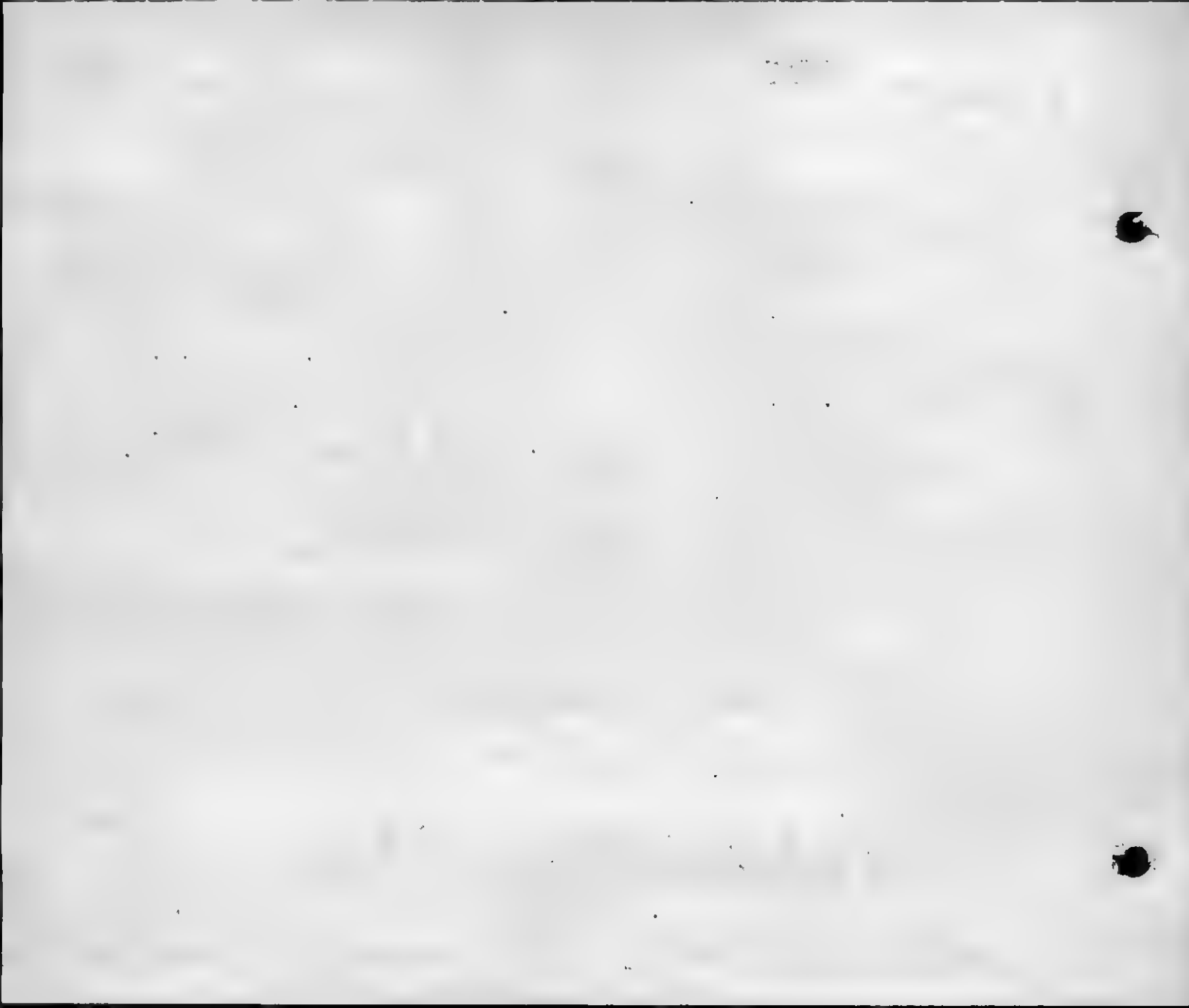
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3617

03612

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sharpsburg</u> d. STREET ADDRESS <u>216 Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Ralston Guiney</u>		4. DATE OF DEATH <u>March 21 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19 1915</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Graduate Nurse</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Zachary T. Ralston</u>		14. MOTHER'S MAIDEN NAME <u>Katherine C. Vize</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 34 0880</u>	
17. INFORMANT <u>Mr. Joseph Guiney</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Metastatic Carcinoma</u> (b) <u>Carcinoma of ovary</u> (c) <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 9, 1960</u> to <u>March 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1961</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
22. SIGNATURE <u>Alfred A. Hoffmann</u> M.D.		22b. DATE SIGNED <u>3/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred A. Hoffmann</u>		22d. ADDRESS <u>214 N. Potomac St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred L. Leaf</u> ADDRESS <u>Williamport, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

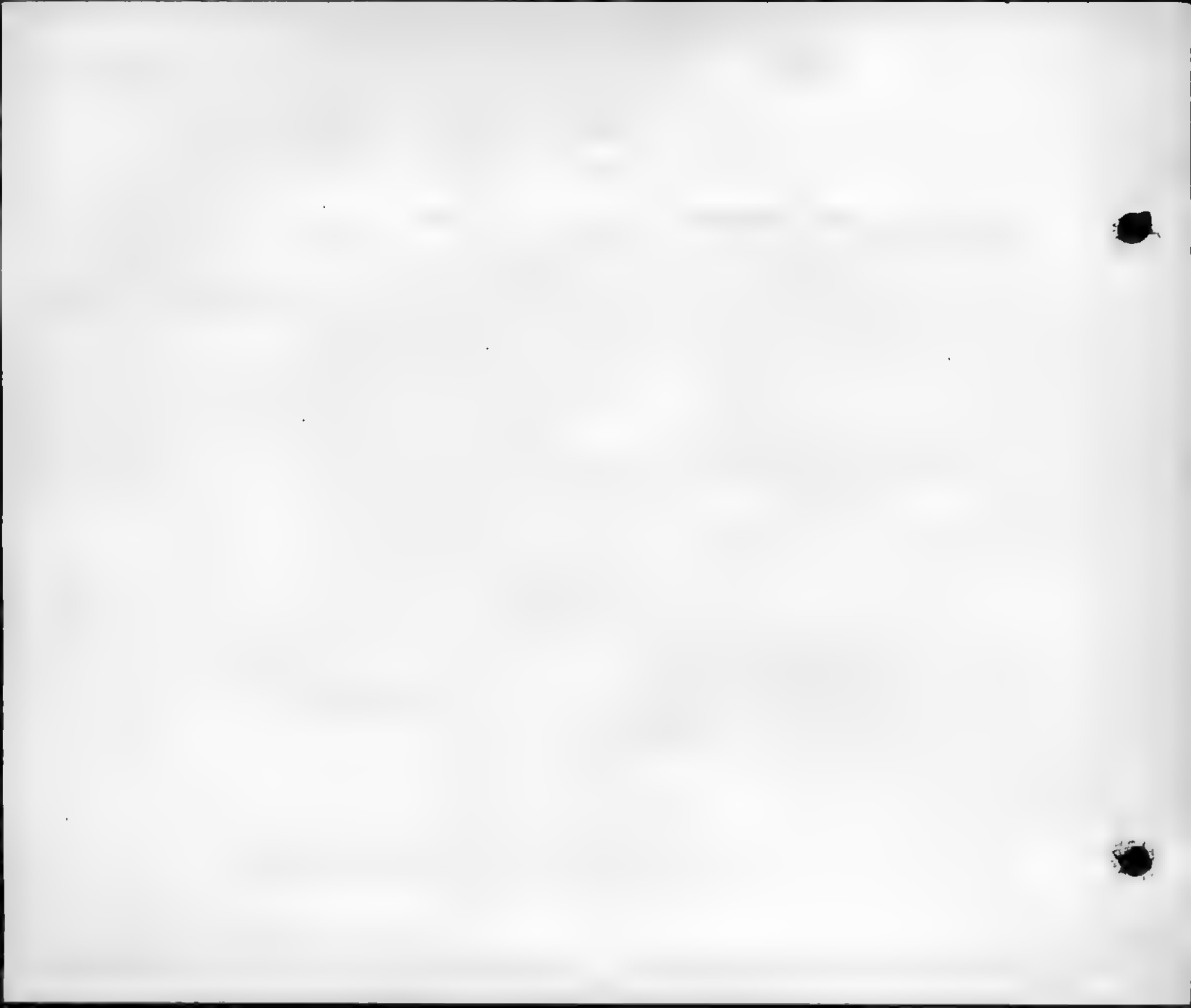


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3618
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03613

1 PLACE OF DEATH a. COUNTY <u>Wash. Co.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George T Hancock</u>				4 DATE OF DEATH Month Day Year <u>MARCH 2, 1961</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIST DESIGNER FLAX, BANNER & PENNANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD.</u>			
11 BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>JOHN T. HANCOCK</u>				14 MOTHER'S MAIDEN NAME <u>ANNIE L. POPE</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service,)				16. SOCIAL SECURITY NO <u>MR. ELMER G. HANCOCK 9149-11121 ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO <u>12-11</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 hr</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> 19 <u>61</u> , to <u>3-2</u> 19 <u>61</u> that (II) (we) last saw the deceased alive on <u>3-2</u> 19 <u>61</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.							
22a SIGNATURE <u>M E Byrkit</u> M.D.				22b DATE SIGNED <u>3-2-61</u>			
22c PHYSICIAN'S NAME (Type) <u>M E Byrkit</u>				22d ADDRESS <u>Williamsport Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE, THEREOF <u>3/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADORIDGE MEM. DORSEY, MD</u>		23d. LOCATION (City, town, or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Esther J. ...</u>				25a REC'D BY REGISTRAR <u>MAR 8 '61</u>			
				25b REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

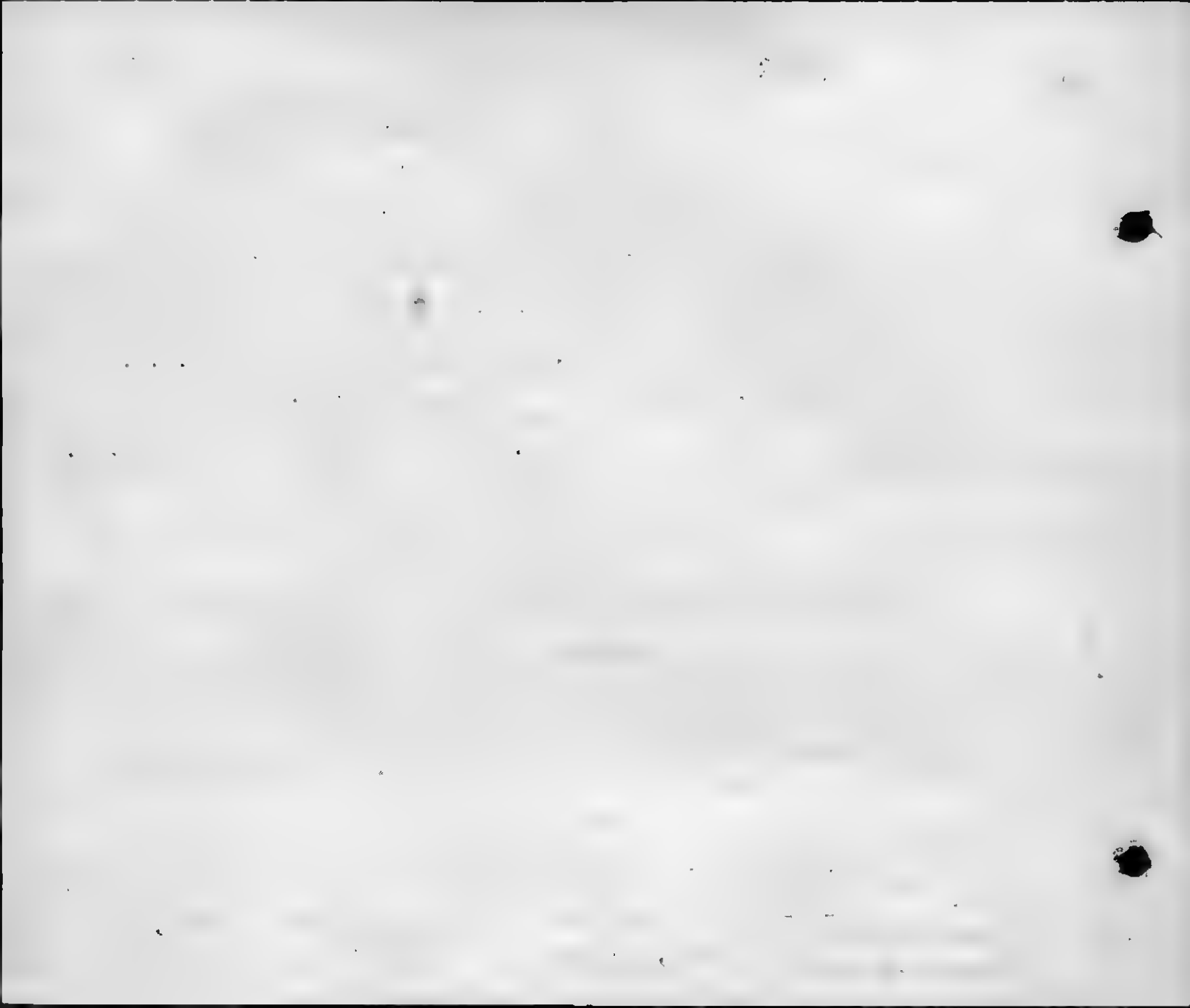
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3619

CERTIFICATE OF DEATH

03614

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hancock Rest Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> d. STREET ADDRESS <u>526 West "B"</u>	
3. NAME OF DECEASED (Type or print) <u>Ida Catherine Hanson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Manager Furniture Store.</u>		9b. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Manager Furniture Store.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward H. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Ella V. Beck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Florence Nicodemus, Brunswick, Md.</u>	
17. INFORMANT <u>Mrs. Florence Nicodemus, Brunswick, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>+ 43 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Heart Failure</u> (a), stating the underlying cause last. (c) <u>Hypertension</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 26, 1957</u> to <u>Mar. 16, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Mar. 17, 1961</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Mar. 17, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. Tyson, M.D.</u>		22d. ADDRESS <u>Gum Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-20-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		23d. LOCATION (City, town or county) (State) <u>Brunswick, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24b. ADDRESS <u>Brunswick, Maryland</u>	
25a. REC'D BY REGISTRAR <u>Charles S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

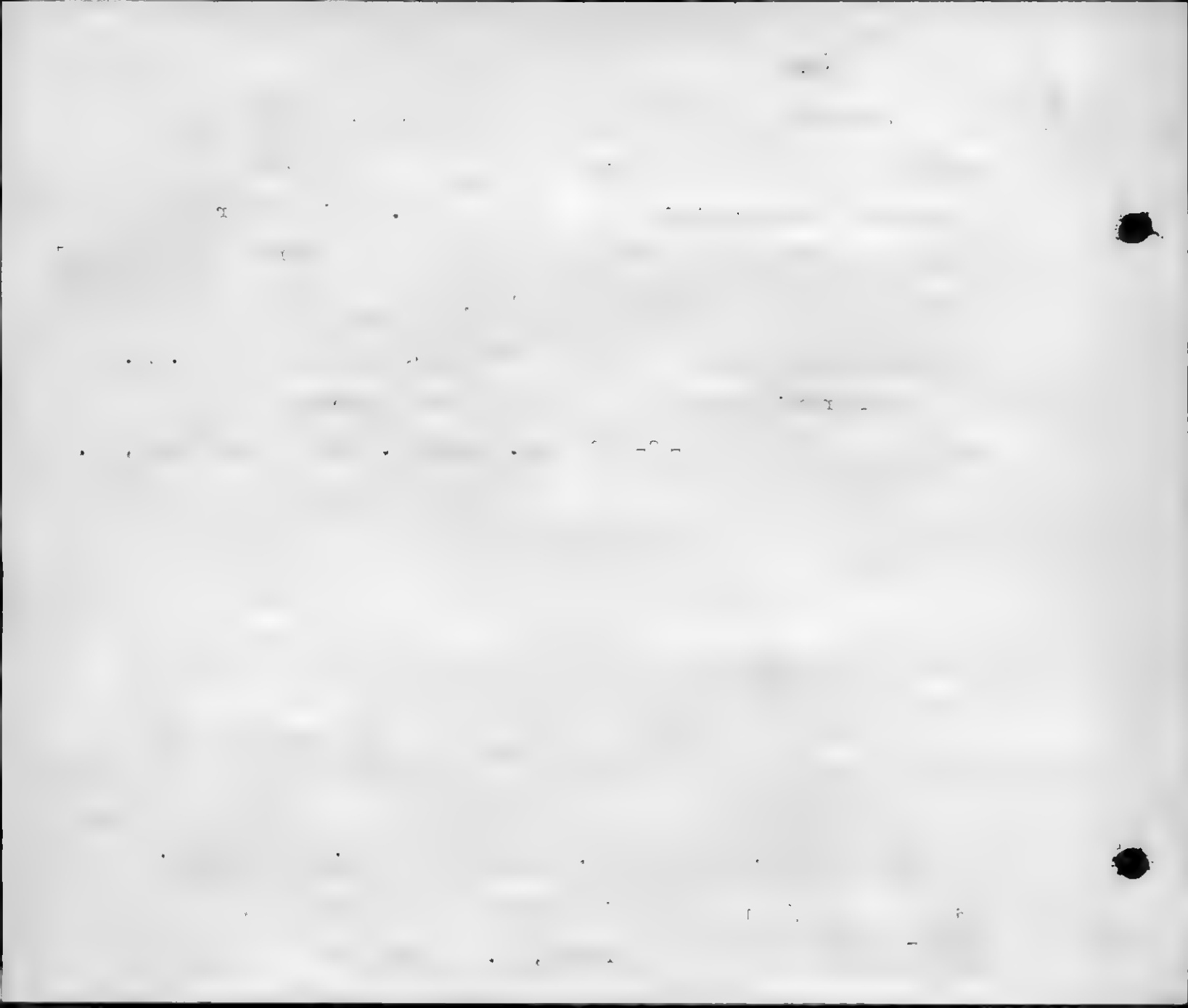
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3620

03615

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 34 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 701 W. Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROZELLA First AGNES Middle HARR Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 4, 1899 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH March 14 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY Steelton, Pennsylvania 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Peter Francis Clark 14. MOTHER'S MAIDEN NAME Mary Ann Murray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-32-3862 16. SOCIAL SECURITY NO. Mrs. Rozella A. Watson Philadelphia, Pa. 17. INFORMANT Mrs. Rozella A. Watson Philadelphia, Pa. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis, General PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 10 yrs 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED Oct 20 1957 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 13 1961 20f. (City or town) Hagerstown (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from March 13 1961 to March 14 1961 , that (I) (we) last saw the deceased alive on March 13 1961 , and that death occurred at 12 M. from the causes and on the date stated above.		22a. SIGNATURE Philip J. Hirshman M.D. 22b. DATE SIGNED 3/14/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/16/1961 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) Hagerstown, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Reizer ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR DATE MAR 17 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

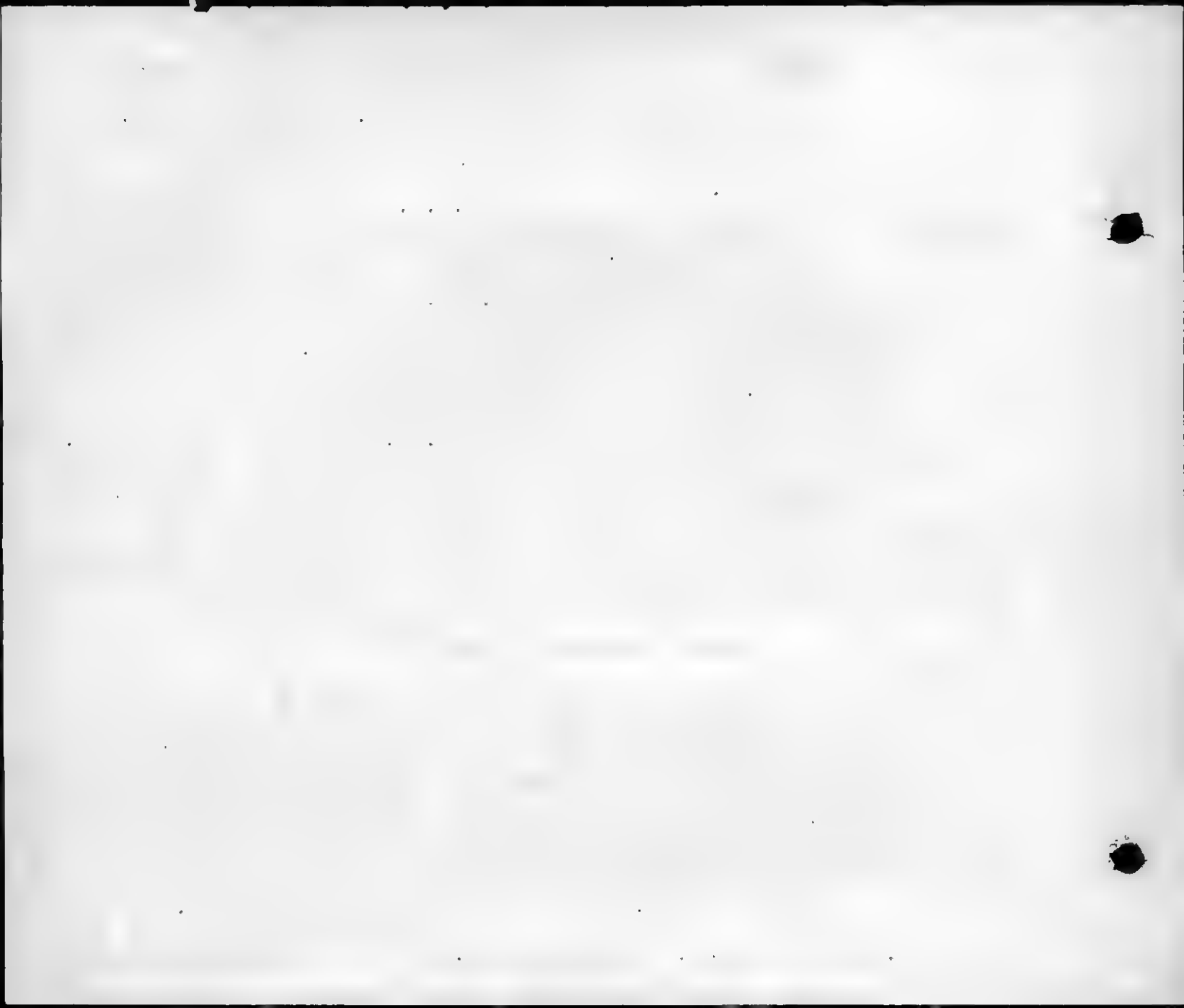
3621

02616

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS R.F.D. 2	
3. NAME OF DECEASED (Type or print) First Ruth Middle Naomi Last Harris		4. DATE OF DEATH Month March Day 30 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1889
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard P. Hagan		14. MOTHER'S MAIDEN NAME Mary Ellen Keyser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Charles G. K. Harris, Boonsboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 10/1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 31, 1889 to March 31, 1961 , that (I) (we) last saw the deceased alive on March 31, 1961 , and that death occurred at 9 M. from the causes and on the date stated above.			
22a. SIGNATURE Scott F. Minnich & Son		22b. DATE SIGNED 3-31-61	
22c. PHYSICIAN'S NAME (Type) Scott F. Minnich & Son		22d. ADDRESS Boonsboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-1-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE 4-1-61	
25b. REGISTRAR'S SIGNATURE Scott F. Minnich & Son			

(81)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3629

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03617

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u>				c. LENGTH OF STAY IN 1b <u>30 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LABEL</u> Middle <u>A</u> Last <u>HASSETT</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 5 1874</u>		9. AGE (in years lost birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Big Spring Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hassett</u>				14. MOTHER'S MAIDEN NAME <u>Sara Edelen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Elizabeth Ankeney Big Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>442 X</u> IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> 19 <u>59</u> to <u>March 13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>March 12</u> 19 <u>61</u> and that death occurred at <u>11.30</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>Archie Robert Cohen</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Little Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clear Spring Wash Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Colman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

ES 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3623
CERTIFICATE OF DEATH
03618

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>20 N. Artizan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Garfield</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Boss</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. R. R.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>
13. FATHER'S NAME <u>Levi Henry</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wisenburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-9864</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>435.0</u> DUE TO <u>Cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Atherosclerosis & congestive failure</u> DUE TO <u>5-ys</u> (c) <u>10 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Williamsport</u>		20f. (City or town) (County) (State) <u>Williamsport Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20 1961</u> to <u>March 28, 1961</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>March 28, 1961</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u> M.D.		22b. DATE SIGNED <u>3-30-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Diverview Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Wolf</u>		25a. REC'D BY REGISTRAR <u>Williamsport, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>Williamsport, Md.</u>	

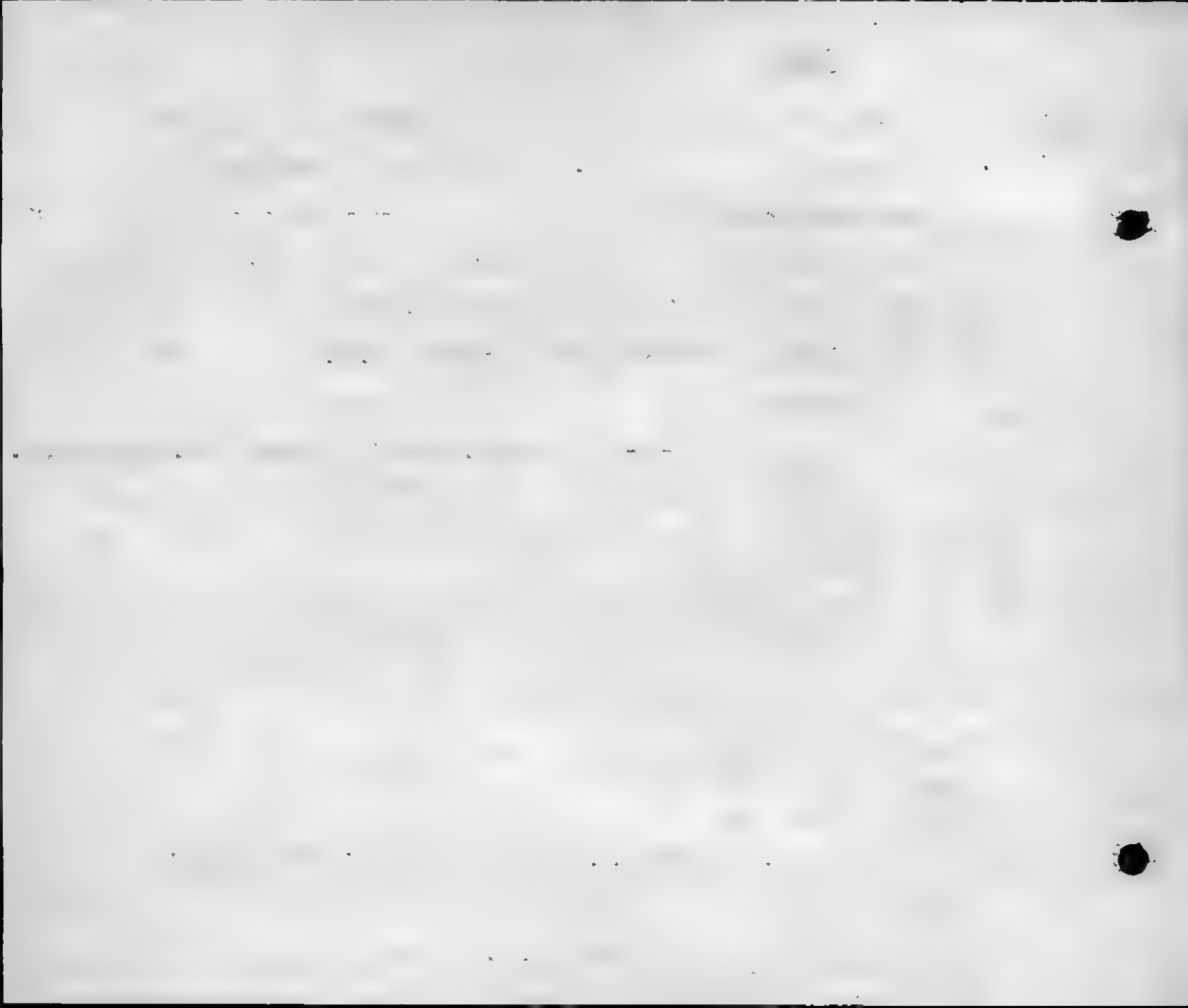


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
3624 CERTIFICATE OF DEATH 03619													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 Mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring R # 1</u> d. STREET ADDRESS <u>-----</u>									
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Henry</u> Last <u>Hesson</u>				4. DATE OF DEATH <u>March</u> <u>14</u> <u>1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 29, 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u>			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>				12. KIND OF BUSINESS OR INDUSTRY <u>Milk Processing</u>				13. BIRTHPLACE County & State, or foreign country <u>Frederick Co. Md.</u>					
14. FATHER'S NAME <u>Jacob Peter Hesson</u>				15. MOTHER'S MAIDEN NAME <u>Mary Ann Mercer</u>				16. CITIZEN OF WHAT COUNTRY <u>USA</u>					
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 18. SOCIAL SECURITY NO. <u>214-09-3182A</u> 19. INFORMANT <u>Paul R. Hesson</u> Address <u>351 Elizabeth Ave. Hagerstown, Md.</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>---</u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Bicuspid Aortic Valve and Rt. Infarcted Area</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>---</u> p.m. <u>---</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>					
20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>				21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1961</u> to <u>March 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 14, 1961</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. DATE SIGNED <u>3/15/61</u>				22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/17/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>					
23d. LOCATION (City, town or county) <u>Hagerstown</u>				23e. (State) <u>Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>					
25a. REC'D BY REGISTRAR <u>---</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>				DATE <u>MAR 20 '61</u>					

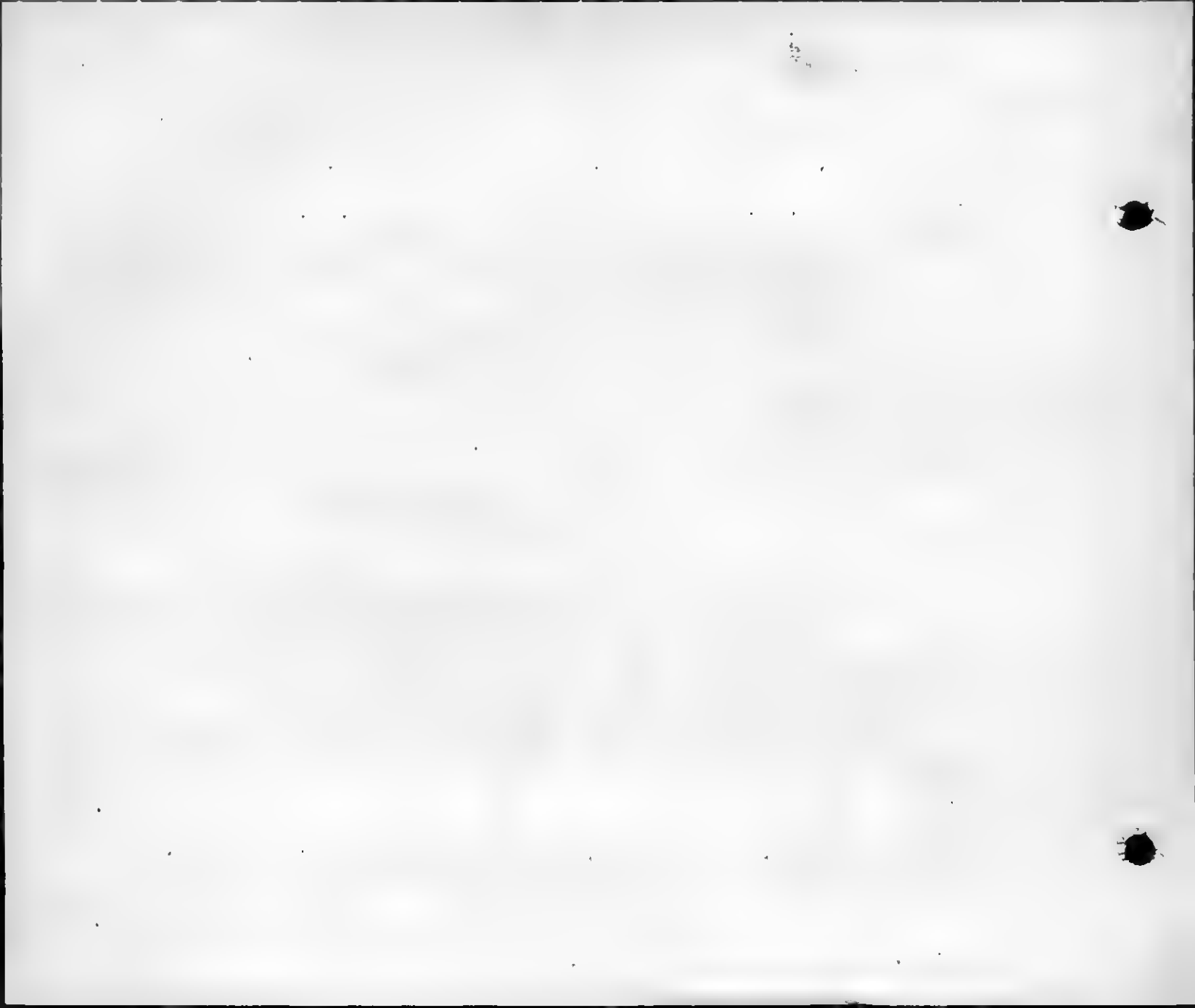


3625

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03640

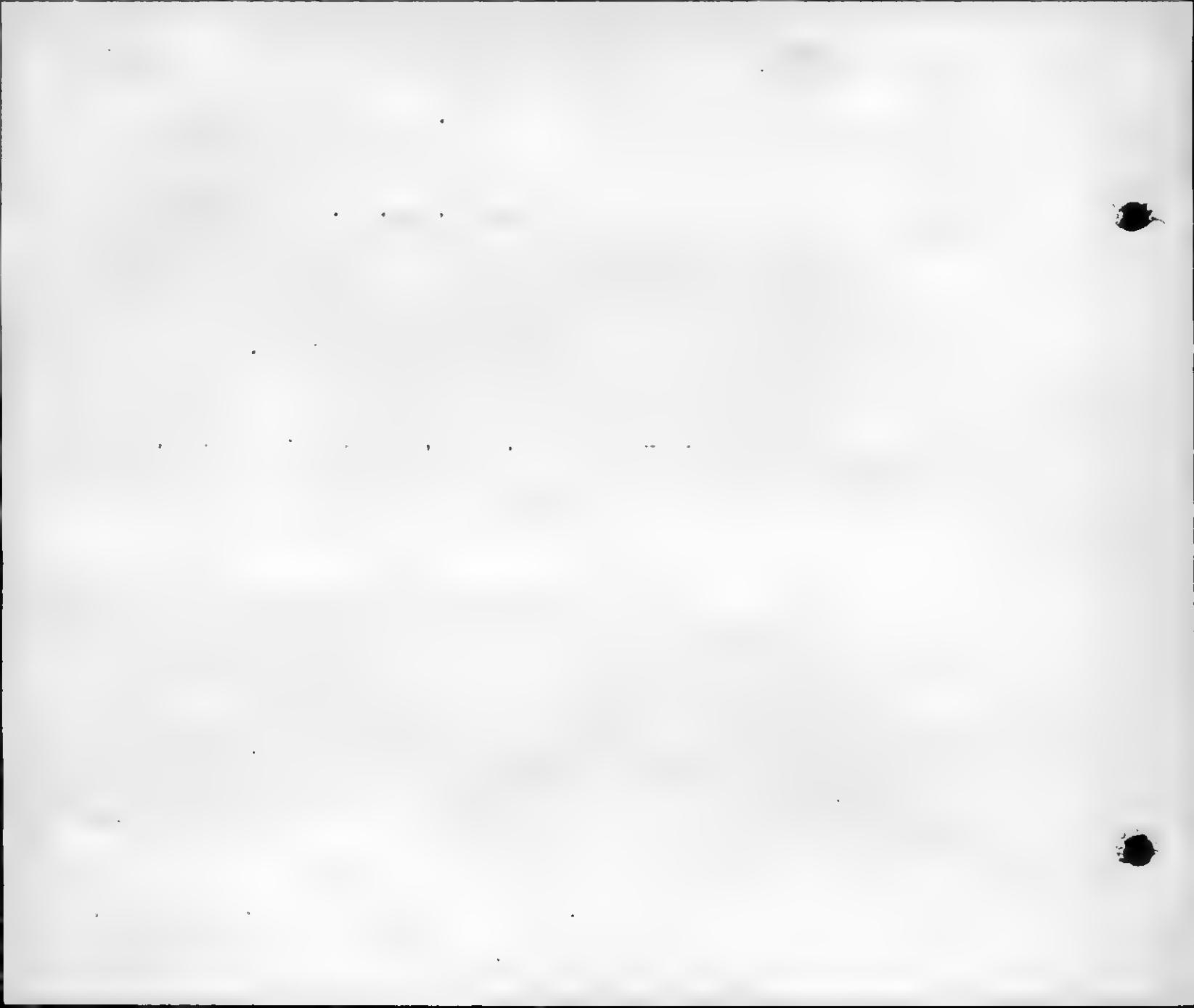
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rt. #4</u>				c. LENGTH OF STAY IN 1b <u>37 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cearfoss Wash. Co. Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>WESLEY</u> Last <u>HOLLINGER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pester-Long</u>		11. BIRTHPLACE (State or foreign country) <u>Cearfoss Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>David Hollinger</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Welch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>312-14-6369</u>		17. INFORMANT <u>Harry D. Spickler Greencastle Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>				R # <u>2</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 9 1957</u> to <u>March 31 1961</u> , that (I) (we) lost saw the deceased alive on <u>3/27</u> 19 <u>61</u> , and that death occurred at <u>12:58</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>		22c. DATE SIGNED <u>4/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lt Zion Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>near Cearfoss Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

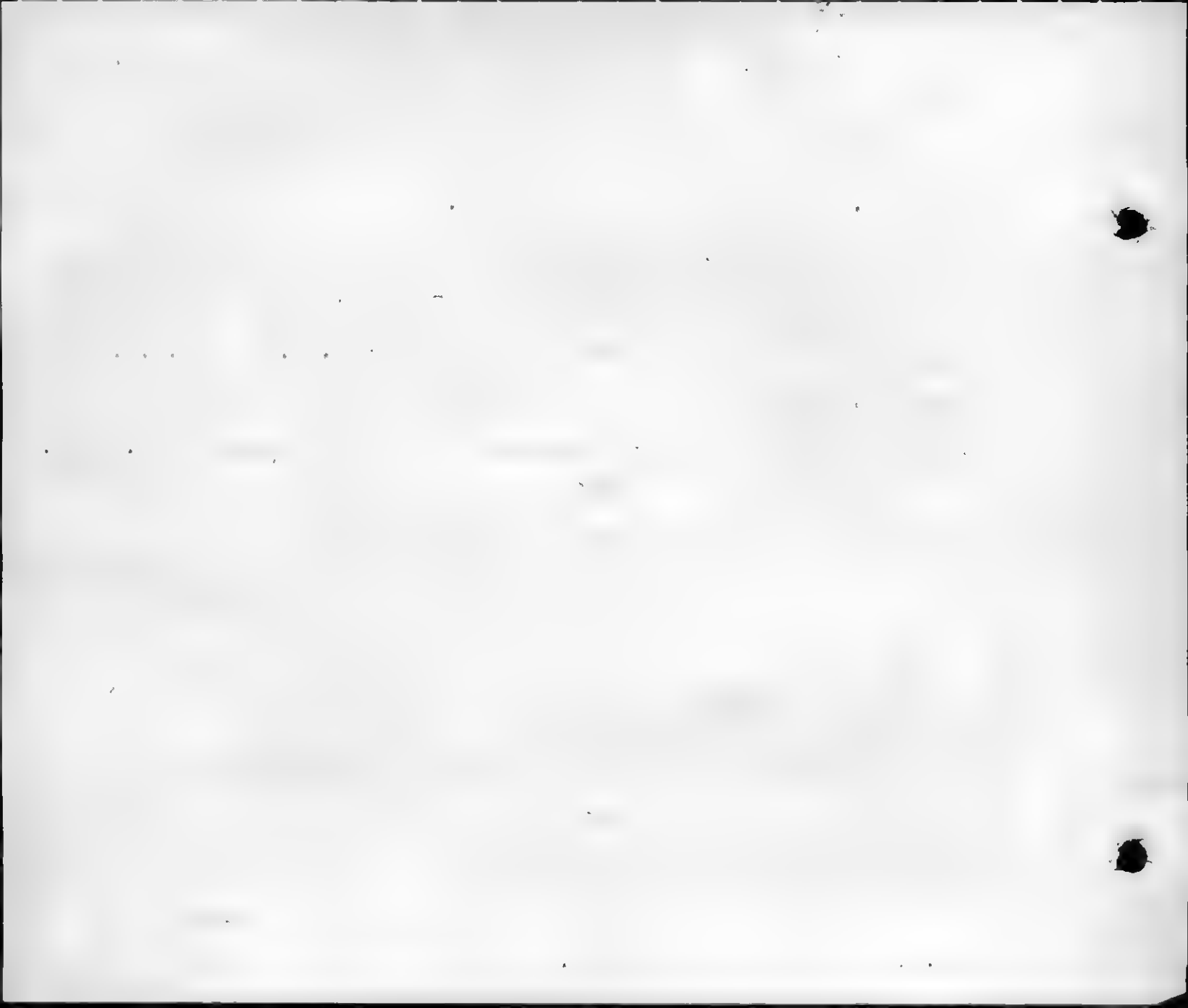
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY <i>Morristown</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Franklin</i> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Leesville</i>					c. LENGTH OF STAY IN 1b <i>6 Years</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Johns Hopkins Memorial Home for Aged</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>OLIVE</i> Middle <i>SNADER</i> Last <i>HORST</i>					4. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>1961</i>				
5 SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <i>2/28/1895</i>		9. AGE (In years last birthday) <i>86</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Duties</i>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <i>Near New Windsor Pa.</i>					12 CITIZEN OF WHAT COUNTRY? <i>US</i>				
13. FATHER'S NAME <i>Evan Thomas Snader</i>					14. MOTHER'S MAIDEN NAME <i>Eliza Ecken Baile</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>173-03-0956A</i>				
17. INFORMANT <i>Mrs. Ida M. Baker, Waynesboro, Pa.</i>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs.</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>p. m.</i> <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>February 10, 1961</i> to <i>March 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 26, 1961</i> , and that death occurred at <i>2:33 P.M.</i> from the causes and on the date stated above									
22a. SIGNATURE <i>G. W. Helan</i>					22b. DATE SIGNED <i>3/29/61</i>				
22c. PHYSICIAN'S NAME (Type) <i>G. W. Helan</i>					22d. ADDRESS <i>Boonsboro Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>3/29/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>			23d. LOCATION (City, town, or county) (State) <i>Waynesboro, Franklin Co., Pa.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Director 2nd St. Waynesboro Pa.</i>					25a. REC'D BY REGISTRAR DATE <i>APR 3 '61</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>		



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3627 CERTIFICATE OF DEATH 03642

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>				d. STREET ADDRESS <u>500 W. South Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>V.</u> Last <u>Hurd</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27- 1885 ?</u>	
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick-Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Hoarse T. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Arianna Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-5240</u>		17. INFORMANT <u>Rosetta Duffins-22 Carver Apts. Fred. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>general arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>unknown</u> <u>"</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, benign</u> (b) <u>cerebral hemorrhage</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>January 17, 1961</u> , to <u>March 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Victor L. Ramos</u>				22b. DATE SIGNED <u>March 20, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>				22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. NICKS III</u>				25a. REC'D BY REGISTRAR <u>MAR 22 '61</u>			
ADDRESS <u>Frederick-Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3628

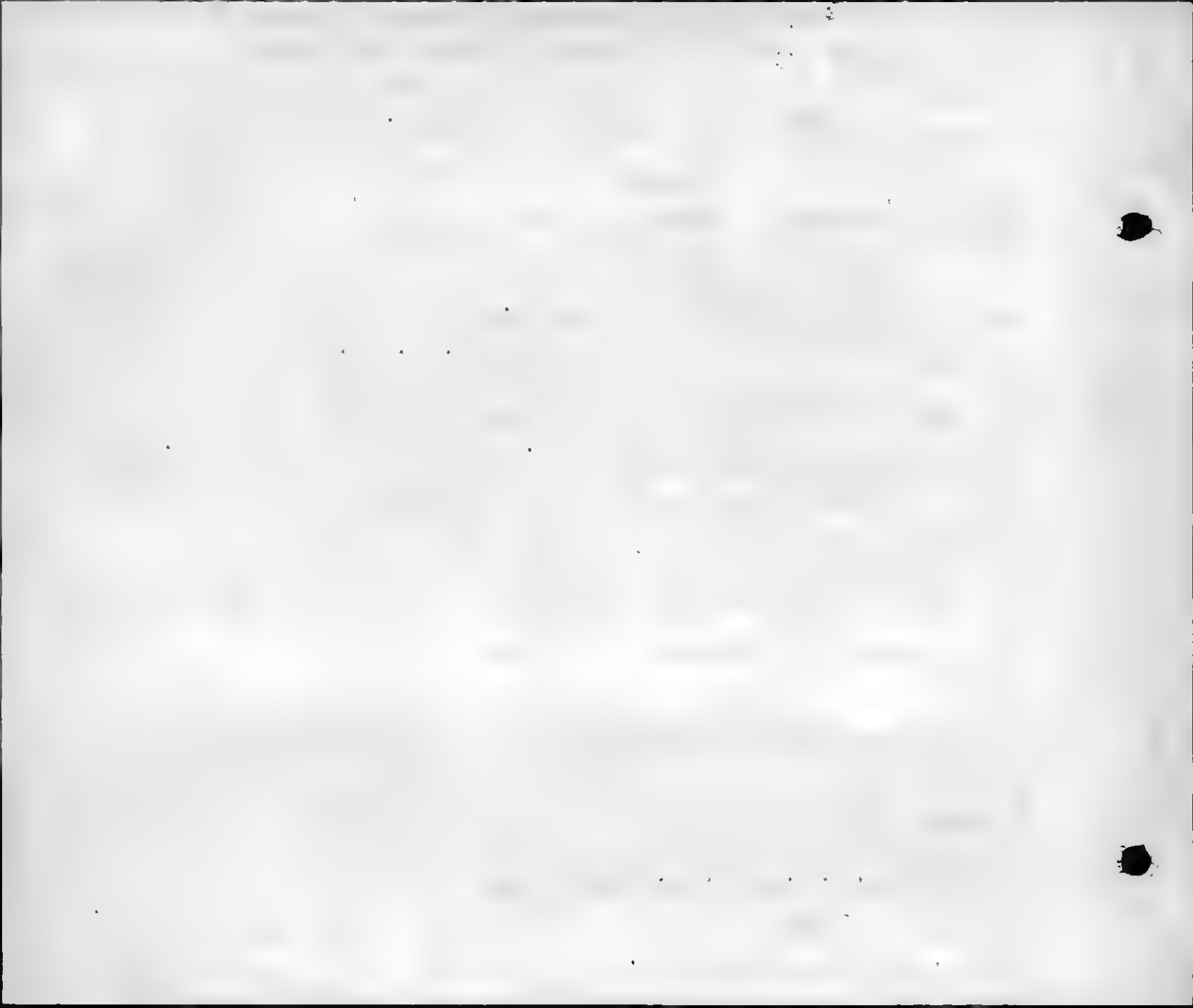
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03628

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tracys' Lane				d. STREET ADDRESS 728 Tracys' Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Solomon Earl Jacobs				4. DATE OF DEATH Month Day Year 3 10 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1891		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jacobs				14. MOTHER'S MAIDEN NAME Lucillia Mongan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-9301		17. INFORMANT Mrs. Irene Jacobs Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart Disease 4-00 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. W. Ditto</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3-11-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-13-61		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



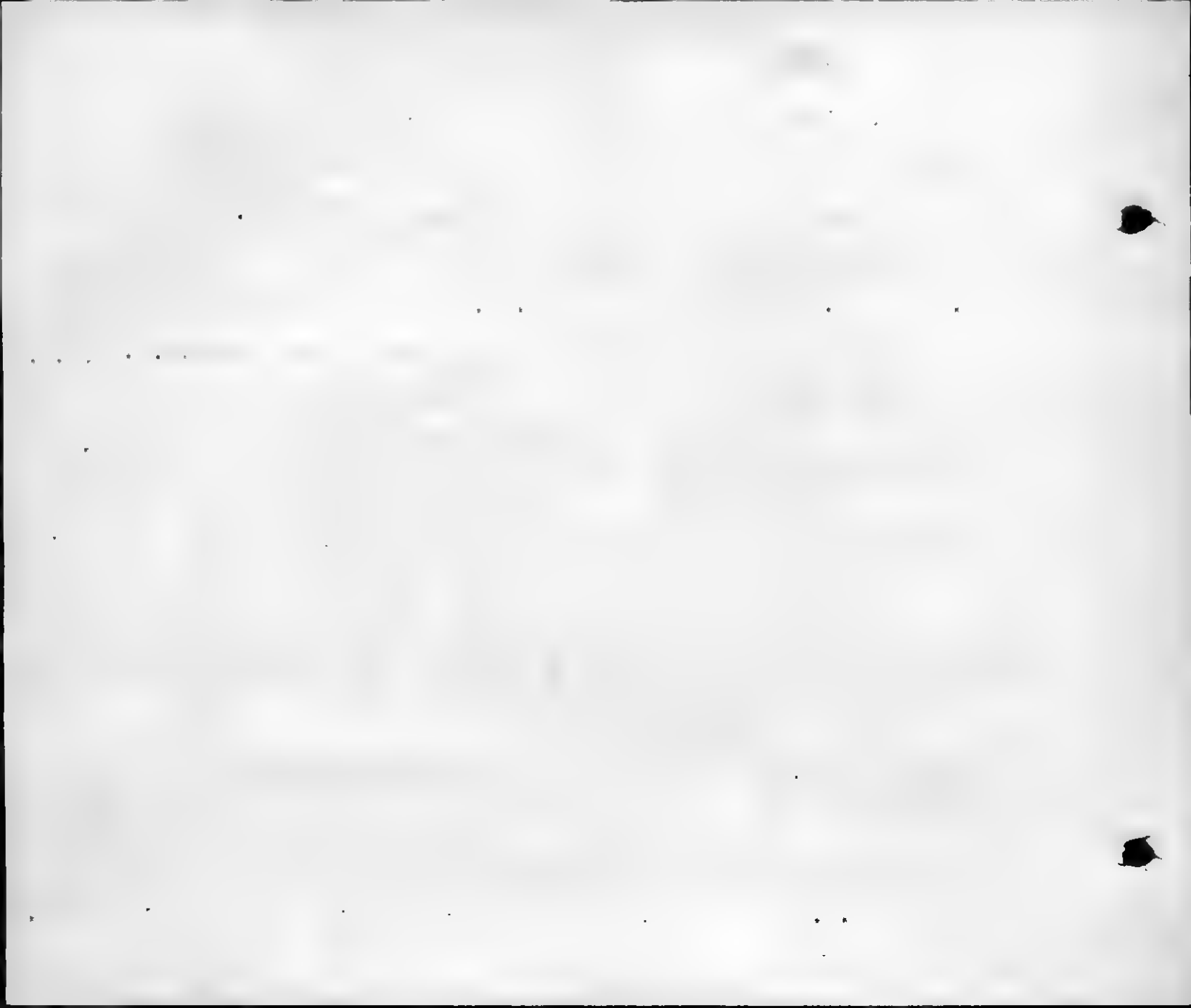
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 ISM 9/59

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 3629 CERTIFICATE OF DEATH 03624

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Pool Maryland				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. STREET ADDRESS Rural 2 Hancock Md.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Blanche Middle Micleta Last Keefer				4. DATE OF DEATH Month 3 Day 6 Year 19 61			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2.14.1891		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Washington County Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Grant Myers				14. MOTHER'S MAIDEN NAME Amanda Shives			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Emmert L Keefer Rural 2 Hancock Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Endocarditis DUE TO (b) Arterial Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 15, 1960 to Mar 6, 1961 , that (I) (we) last saw the deceased alive on Mar 5, 1961 , and that death occurred at Home from the causes and on the date stated above							
22a. SIGNATURE David R. Brewer				22b. DATE SIGNED 3/5/61		22c. PHYSICIAN'S NAME (Type) David R. Brewer	
22d. ADDRESS Clear Spring Md.							
23a. BURIAL, CREMATATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3.9.61		23c. NAME OF CEMETERY OR CREMATORY Rehobeth Methodist		23d. LOCATION (City, town, or county) (State) Rural Fulton County Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Moore Hancock Md.				25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE Charles L. Thomas	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

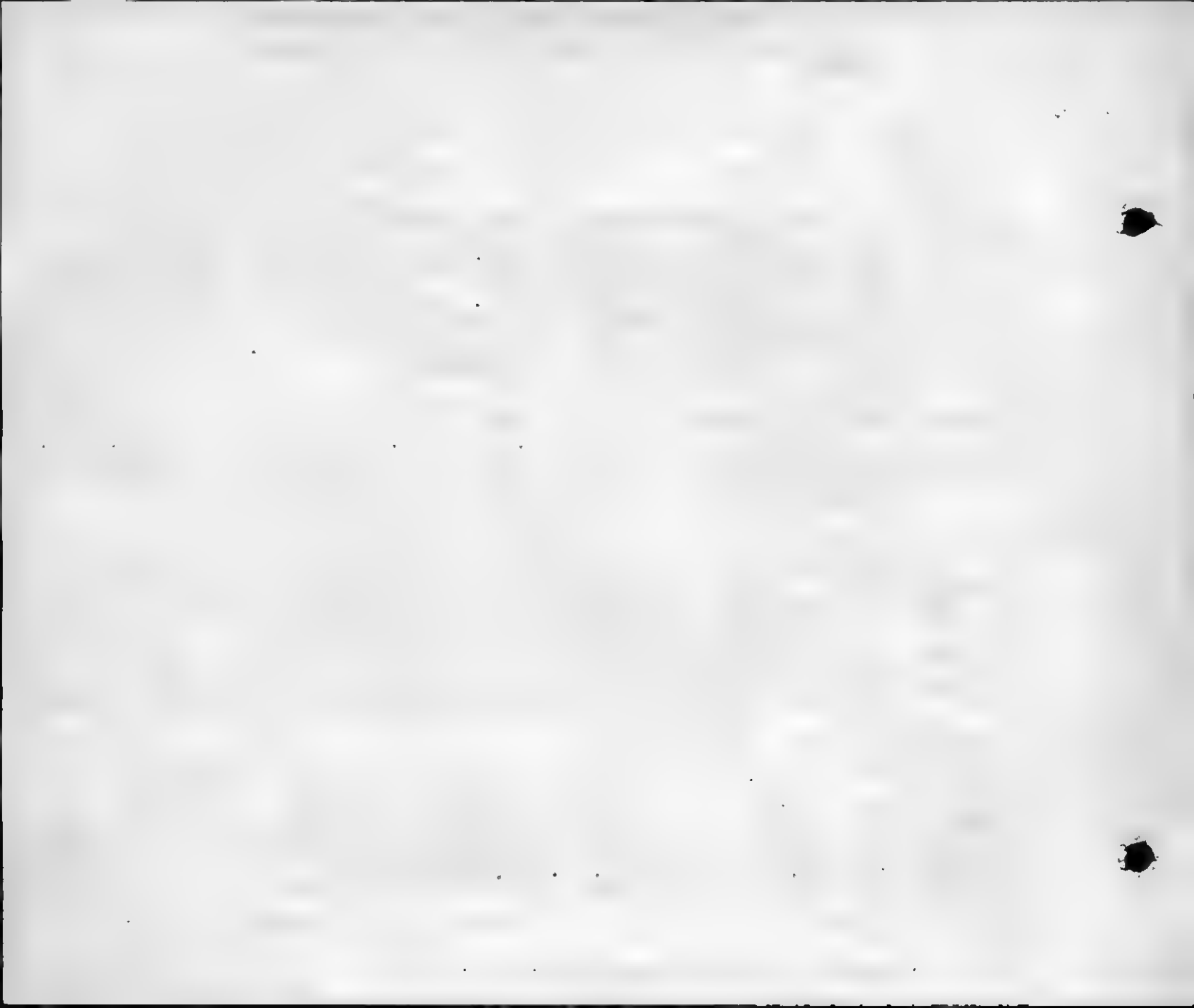
Reg. Dist. No. 03625

3630

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 141 Devonshire Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lester Mason Keller Sr.				4. DATE OF DEATH Month Day Year March 24 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1899		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Near Cearfoss, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elmer Keller				14. MOTHER'S MAIDEN NAME Mary Toms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Wanda L. Keller Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycobacterial Infection</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic heart Disease</u> DUE TO (c) <u>Coronary Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/25/61	
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-61		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown, Md.				24a. REC'D BY REGISTRAR MAR 28 '61		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3631

03626

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>10 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FLORENCE WOOD CHURCH HOME</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>505 FRIEDRICK ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>EULALIE</u> Last <u>LAMAR</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1961</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 10 1881</u>			
9. AGE (In years last birthday) <u>79</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>LEITERSBURG WASH. CO. MD. U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>ROBERT LAMAR</u>			14. MOTHER'S MAIDEN NAME <u>NELLIE EAKLE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. ROSS BOWARD</u> Address <u>HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>477.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure</u> DUE TO (c) <u>Myocardial enlargement</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>Mar 10 1961</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>61</u> and that death occurred at <u>3A</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Louis G. Graff</u>		22b. PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF</u>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. MED. DIRECTOR <input type="checkbox"/> 22e. STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS <u>119 E. Antietam St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 12 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			
23d. LOCATION (City, town, or county) <u>BOONSBORO WASH. CO. MD</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Paul</u>		24a. ADDRESS <u>BOONSBORO MD</u>		24b. DATE <u>MAR 15 '61</u>			

MEDICAL CERTIFICATION

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M

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DR. L. GRAFF

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

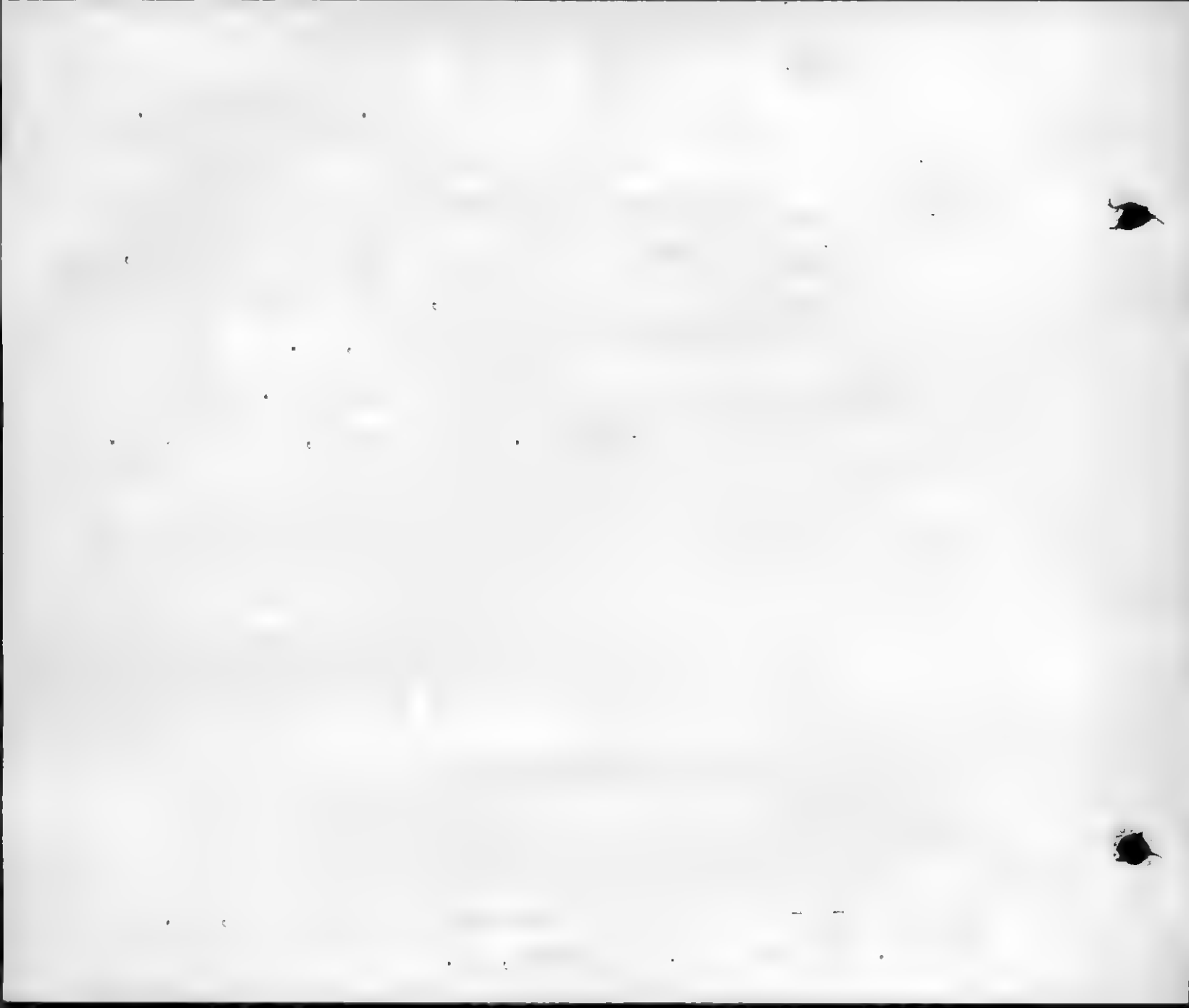
3632

03627

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 11 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cavetown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Box 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Keifer Middle Edward Last Lewis				4. DATE OF DEATH Month March Day 18, Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1901	
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min 59		11. BIRTHPLACE (State or foreign country) Wolfsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor				10b. KIND OF BUSINESS OR INDUSTRY lumber comapny		11. BIRTHPLACE (State or foreign country) Wolfsville, Md.	
13. FATHER'S NAME Charles Lewis				14. MOTHER'S MAIDEN NAME Etti I. Tracey			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-24-3013			
17. INFORMANT Mrs. Eleanor Lewis, Cavetown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) hypertension DUE TO hypertension (c) hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961 to 1961 , that (I) (we) last saw the deceased alive on 18 March 1961 , and that death occurred at M , from the causes and on the date stated above							
22a. SIGNATURE Scott F. Minnich				22b. DATE SIGNED 3/20/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-21-61		23c. NAME OF CEMETERY OR CREMATORY Cavetown Cemetery		23d. LOCATION (City, town, or county) (State) Cavetown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				25a. REC'D BY REGISTRAR APR 22 1961		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

3633

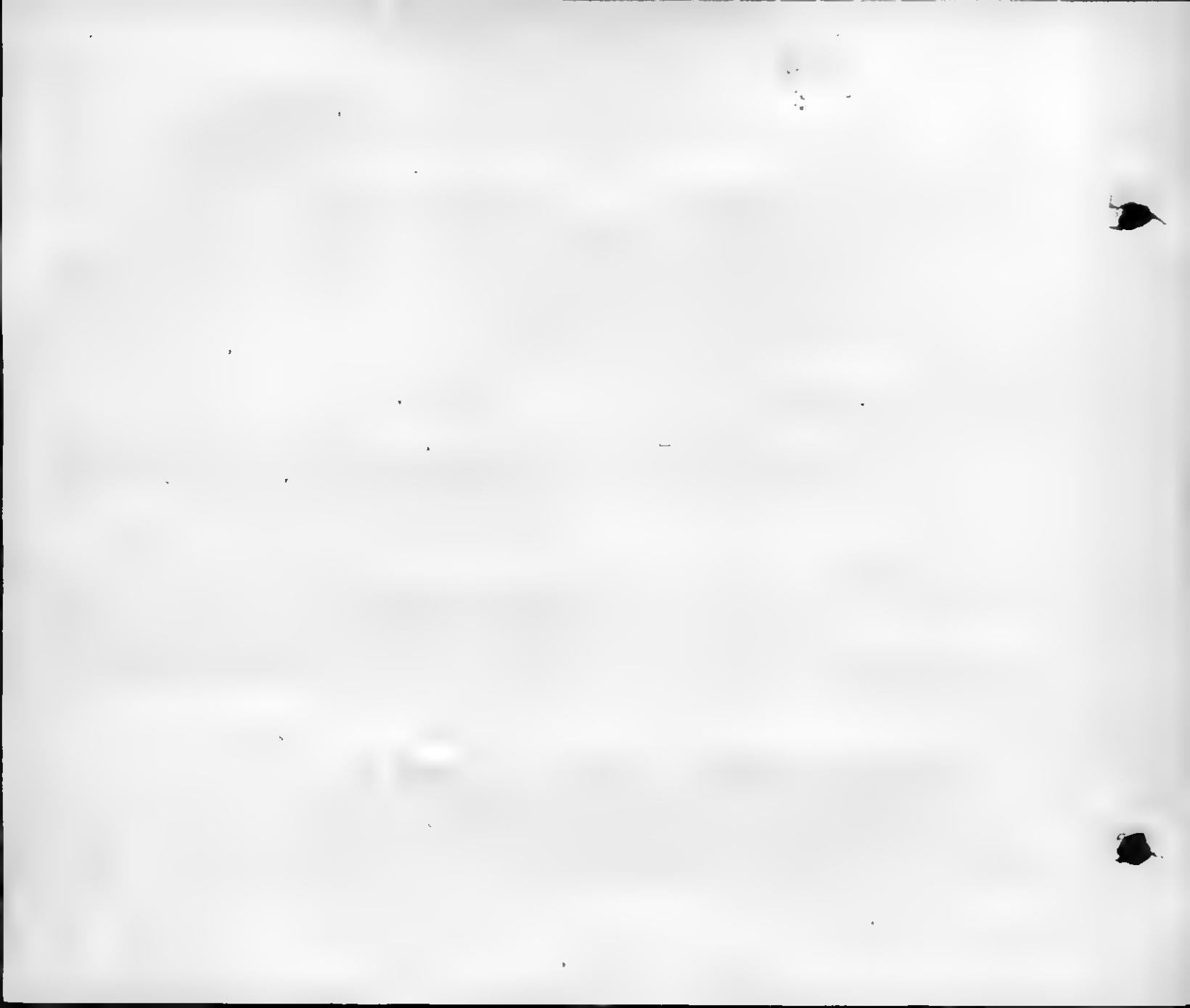
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

302

03628

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 418 Fremont St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ELMER LONG		4. DATE OF DEATH Month Day Year March 5 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Long		14. MOTHER'S MAIDEN NAME Mary E. McNamee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-09-8034	
17. INFORMANT Mrs Ruth G. Cassidy 80 Devonshire Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circled Sclerotic Cardio-Vascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 30 1960 to March 5 1961, that (I) (my) last saw the deceased alive on March 5 1961, and that death occurred 11 A M, from the causes and on the date stated above.			
22a. SIGNATURE J. B. Beachley		22b. DATE March 9 1961	
22c. PHYSICIAN'S NAME (Type) J. B. Beachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/7/61	
23c. NAME OF CEMETERY OR CREMATORY Salem Reformed Cemetery		23d. LOCATION (City, town, or county) (State) near Cearfoss Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew -K Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE MAR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3634
CERTIFICATE OF DEATH

03629

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before adm-ission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>13 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
f. STREET ADDRESS <u>439 Summit Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUE CATHERINE MACLAY</u>		4. DATE OF DEATH Month Day Year <u>March 3 1961 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 26 1873</u>
9. AGE (n years lost birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Franklin Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clayton Stake</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>203-10-9491</u>	
17. INFORMANT <u>Mrs Bessie Lunday</u>		Address <u>439 Summit Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions if any, which gave rise to immediate cause (b), stating the under-lying cause ast. (b) <u>general arteriosclerosis +</u> DUE TO (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>10-15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - osteoarthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> 19 <u>61</u> to <u>Mar 3</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 3</u> 19 <u>61</u> , and that death occurred <u>at 10:30 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Edward W. DiNo III</u>		22b. DATE SIGNED <u>M.D.</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Smithsburg Wash Co Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
ADDRESS <u>Hagerstown Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION



3635

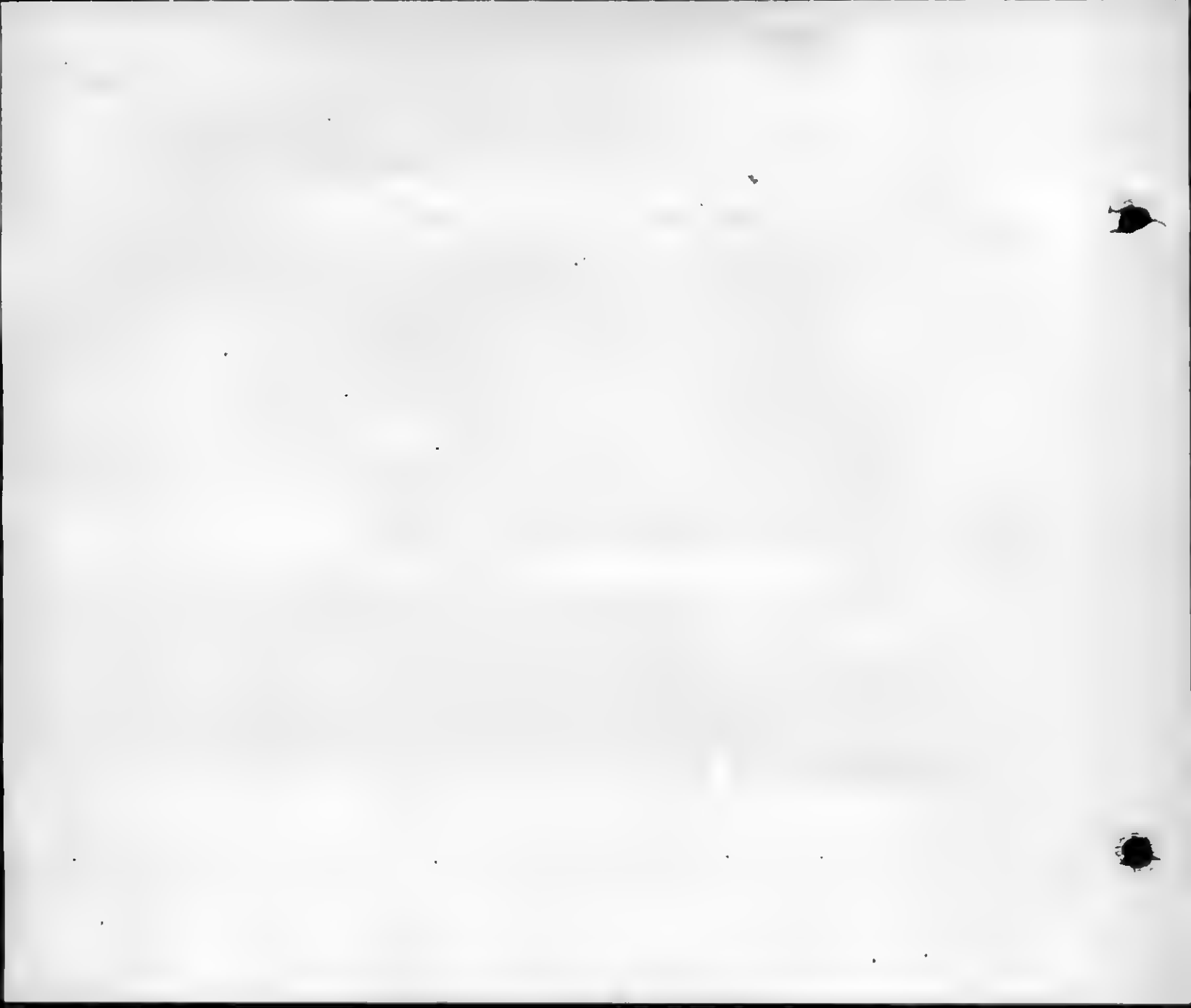
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03680

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Antietam Village</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEARL MARIE McCARRAHER</u>				4. DATE OF DEATH Month Day Year <u>March 14 1961 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12 1892</u>		9. AGE (in years lost birthday) <u>69</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milliner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Berger</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Bragunier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>		17. INFORMANT Address <u>Harry J. McCarragher Antietam Village</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u> <u>Carcinoma of head of Pancreas</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12</u> 19 <u>58</u> to <u>Mar. 14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar. 14</u> 19 <u>61</u> , and that death occurred at <u>A M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John D. Turco</u>				22b. DATE SIGNED <u>3-15-51</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Turco</u>	
22d. ADDRESS <u>302 N. Potomac Street-Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>		25b. REG STRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

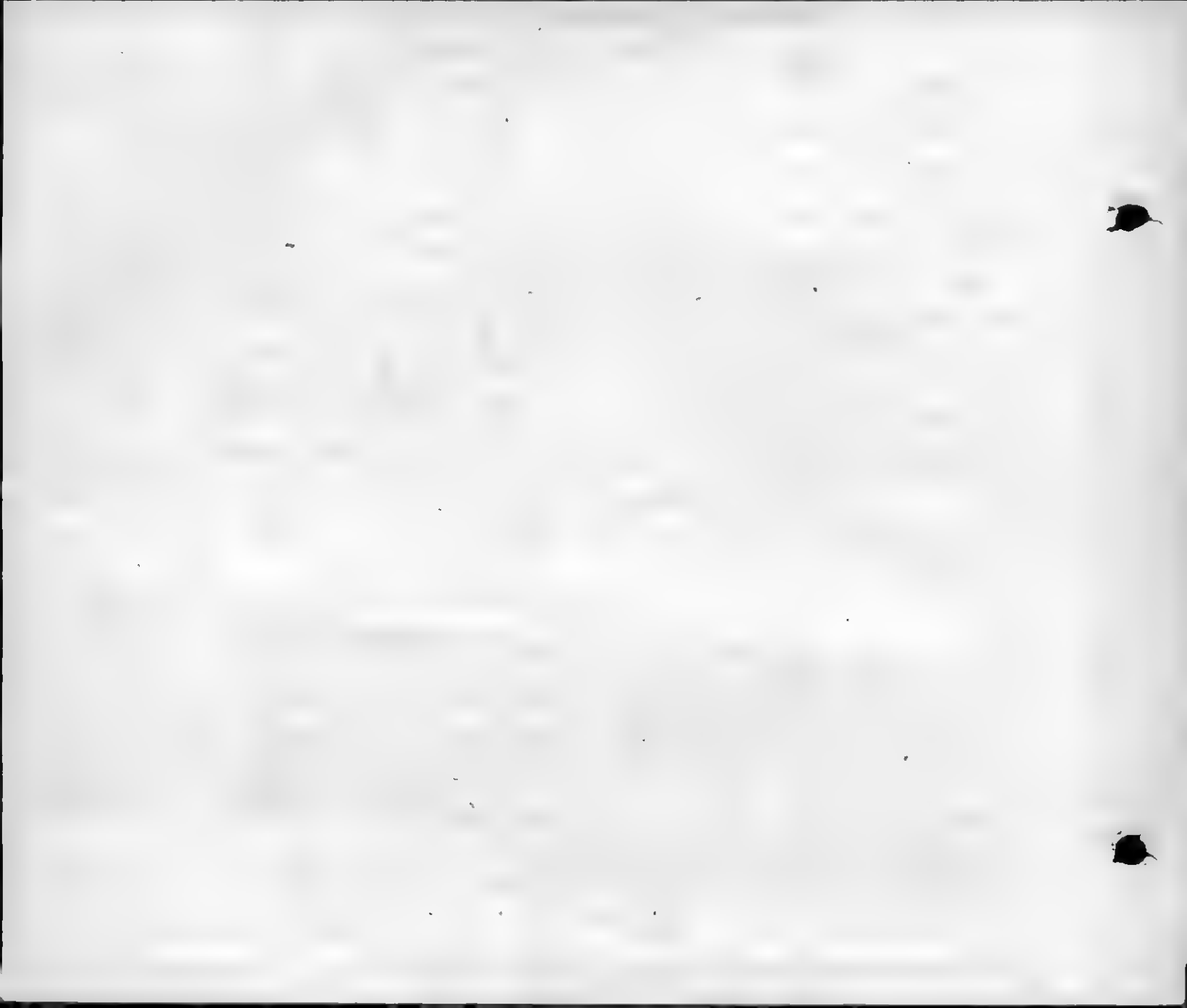
Item 2 Film 3/64 4/7/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

13631

1. PLACE OF DEATH o. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp.</u>		e. STREET ADDRESS <u>Breezewood, East Providence</u>	
3. NAME OF DECEASED (Type or print) <u>Lester Eugene</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Breezewood Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm H. Mellott</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Mellott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>obstructed both lower ureters</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Prostate</u> DUE TO (c) <u>Artery sclerotic heart disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Artery sclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1961</u> to <u>March 28, 1961</u> , that I last saw the deceased alive on <u>March 28, 1961</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Crisp M.D.</u>		ADDRESS (Street, city or town, state) <u>115 King St.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH C. CRISP M.D.</u>		DATE SIGNED <u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-31-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Luth. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Breezewood, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
24b. REGISTRAR'S SIGNATURE			

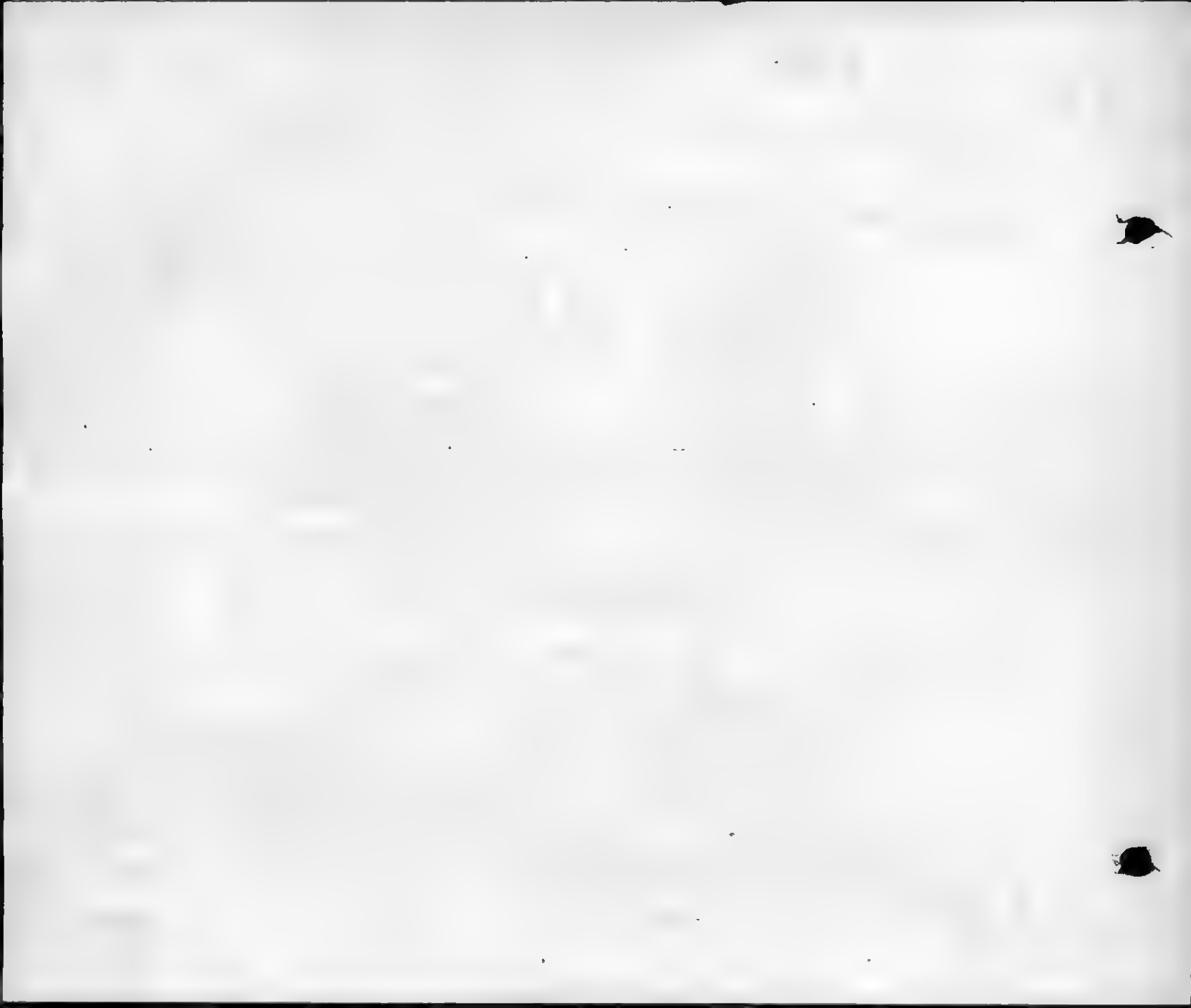


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
 3637
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 03632

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>FRED JEROME MOORE</u>				4. DATE OF DEATH Month Day Year <u>March 9 1961 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26 1871</u>		9. AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Potomac-Edison Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lat Vernon Knox Co</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Flaherty</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>320-09-8909A</u>		17. INFORMANT Address <u>Fla. Box 74</u> <u>Don G. Moore Windermere Orange Co</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1955-57</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>March 8 1961</u> to <u>March 9 1961</u> that (I) (we) last saw the deceased alive on <u>March 8 1961</u> and that death occurred at <u>1955-57</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter H. Sheppard</u>		M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/11/61</u>		22c. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEPPARD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mausoleum Rose Hill Cem Hagerstown Md</u>		23d. LOCATION (City town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>C. S. S. S.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3638

CERTIFICATE OF DEATH

03653

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Md. State Hospital				e. STREET ADDRESS 876 Virginia Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER MOCK R. MULLENIX				4. DATE OF DEATH Month Day Year MARCH 30 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1890		9. AGE (In years lost birthday) 70 yrs	10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY slsmn Bohman Warner		11. BIRTHPLACE (State or foreign country) Rileyville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L Mullenix				14. MOTHER'S MAIDEN NAME Florence L Hoch			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-9436		17. INFORMANT Mrs. Pearl Mullenix		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF COLON 15 5 8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 3-9- 1961 to 3-30 1961 , that (I) (we) last saw the deceased alive on 3-30- 1961 , and that death occurred at 3:45 M, from the causes and on the date stated above							
22a. SIGNATURE Antonio U. Pallagrosi M.D.				22b. ADDRESS 1500 PENNSYLVANIA AVE HAGERSTOWN		22c. DATE SIGNED	
23a. BLUR AL, CREMATION REMOVAL (Specify) burial				23b. DATE THEREOF 4-1-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) Hagerstown				(State) Md.		23e. DATE	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 3 '61	
25b. REGISTRAR'S SIGNATURE Fred W. Kraiss				25c. DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

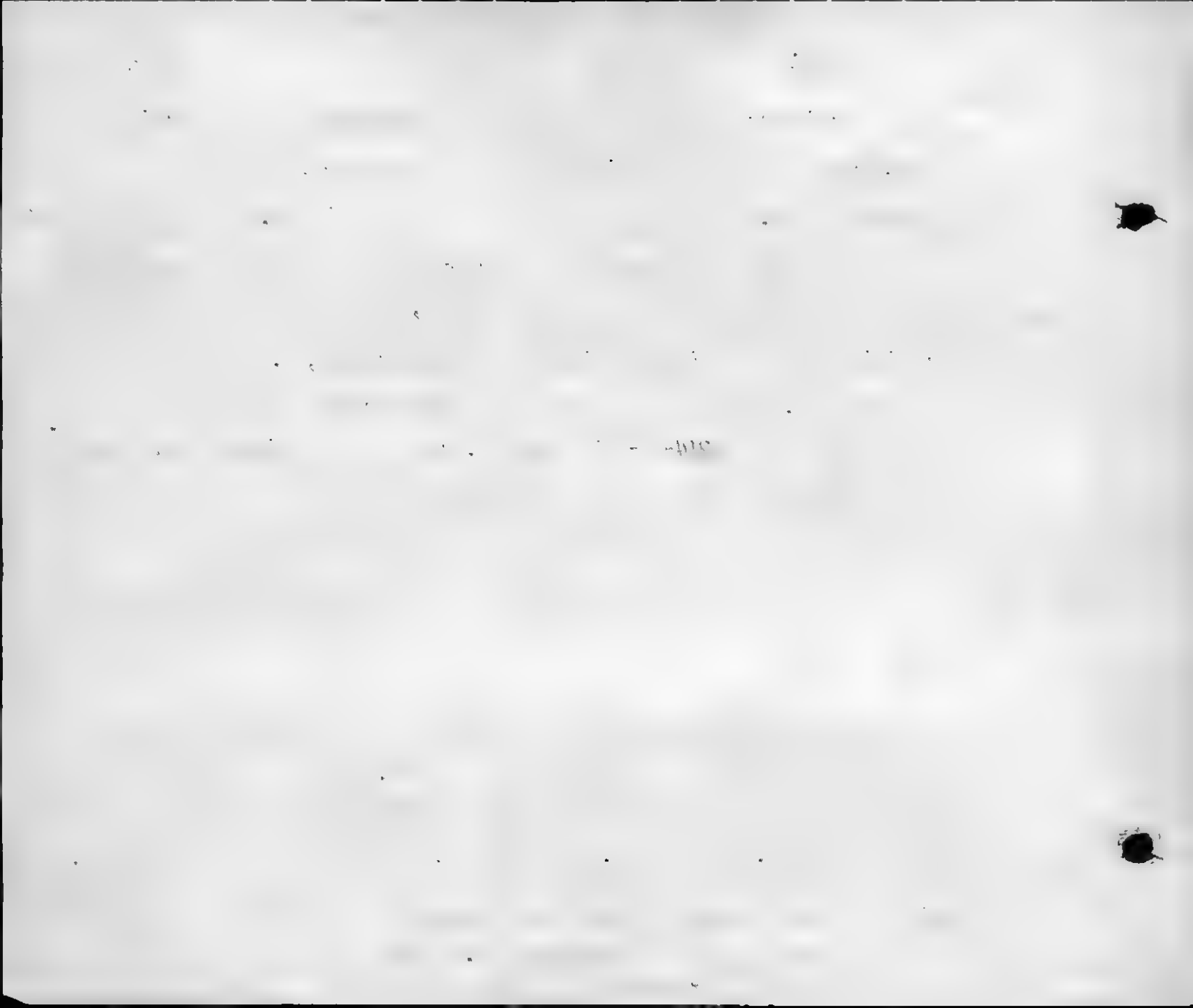
3639

CERTIFICATE OF DEATH

03654

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1024 Main Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission on) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1024 Main Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ray Emmert Munday</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 28, 1902</u>			
9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Norman S. Munday</u> 14. MOTHER'S M maiden name <u>Annie Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-03-6316</u> 17. INFORMANT <u>Eston G. Munday</u> Address <u>2006 Lexington Ave. Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u> </u> <u> </u> <u> </u> , 19 <u> </u> , to <u> </u> <u> </u> <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> <u> </u> <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> <u> </u> <u> </u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Dr. H. W. ...</u> 22b. PHYSICIAN'S NAME (Type) <u> </u> 22c. ADDRESS <u> </u>		22d. ADDRESS <u> </u>		22e. DATE SIGNED <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 14, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hook</u> ADDRESS <u>Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> DATE <u>MAR 15 '61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

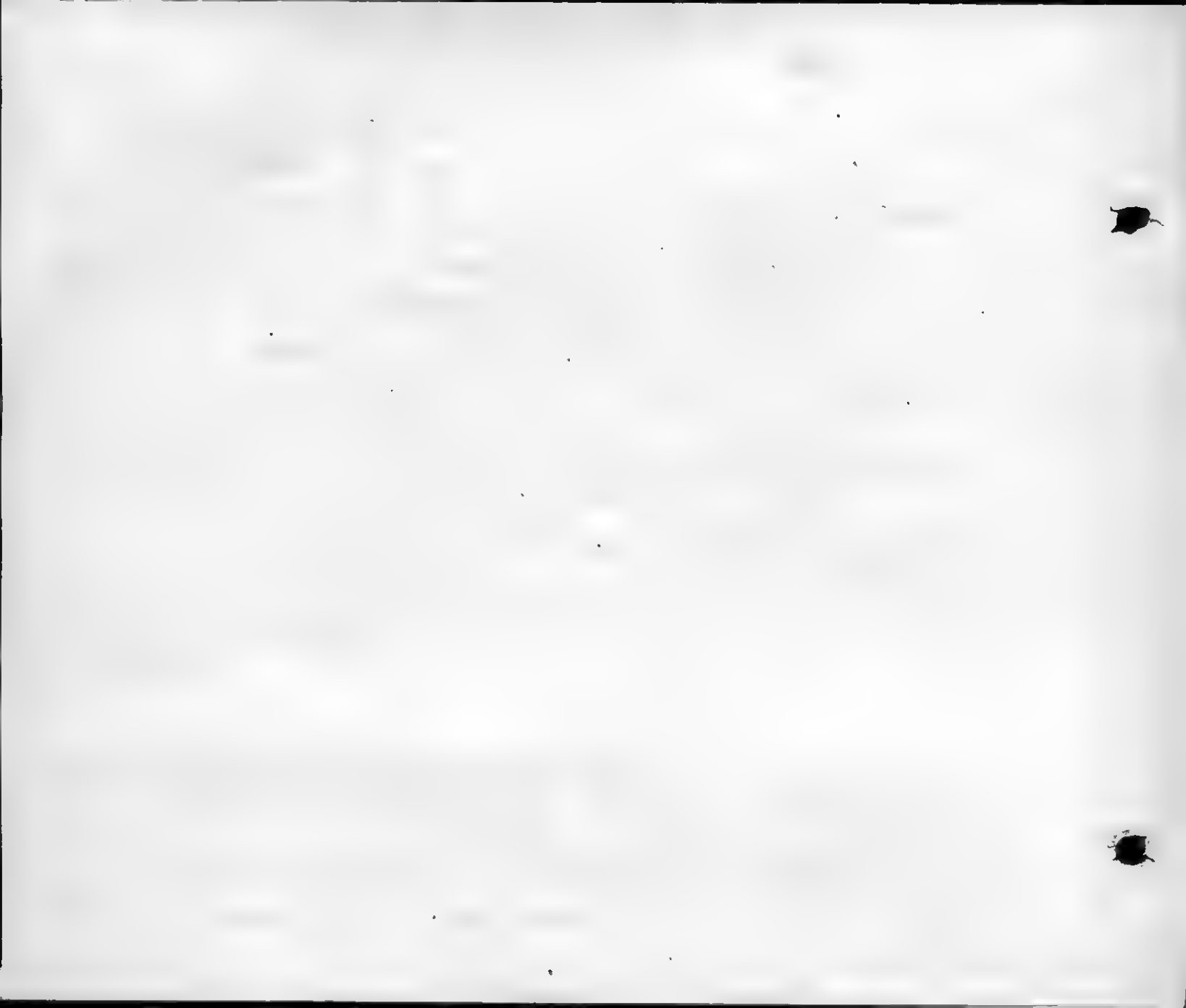
1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

3640

03635

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Penn</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle</u>			
c. LENGTH OF STAY IN 1b <u>1 yr.</u>				d. STREET ADDRESS <u>Route #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #6, Hagerstown</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harvey L. Niswander</u>				4. DATE OF DEATH Month Day Year <u>March 18 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1872</u>	
9. AGE (In years lost birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Martin Niswander</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Meyers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Abram Shank</u> Address <u>Rt. 2, Hagerstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Seminal Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/29, 1959</u> to <u>March 18, 1961</u> , that (I) (we) lost saw the deceased alive on <u>March 17, 1961</u> and that death occurred at <u>8 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>D. R. Hess</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>David R. Hess M.D.</u>				22d. ADDRESS <u>Shady Grove Pa</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>The Meyers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa</u>		25. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION



Items 3 & 4 111-1100-3/22/01-jwk

03600

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>MAR. 16, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>GREENLAWN CEMETERY</i>	23d. LOCATION (City, town, or county) <i>CLARKSBURG, W. VA.</i>	(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John D. East</i>		ADDRESS <i>BOONSBORO MD.</i>	25a. REC'D BY REGISTRAR <i>DAT MAR 21 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur J. Hines</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

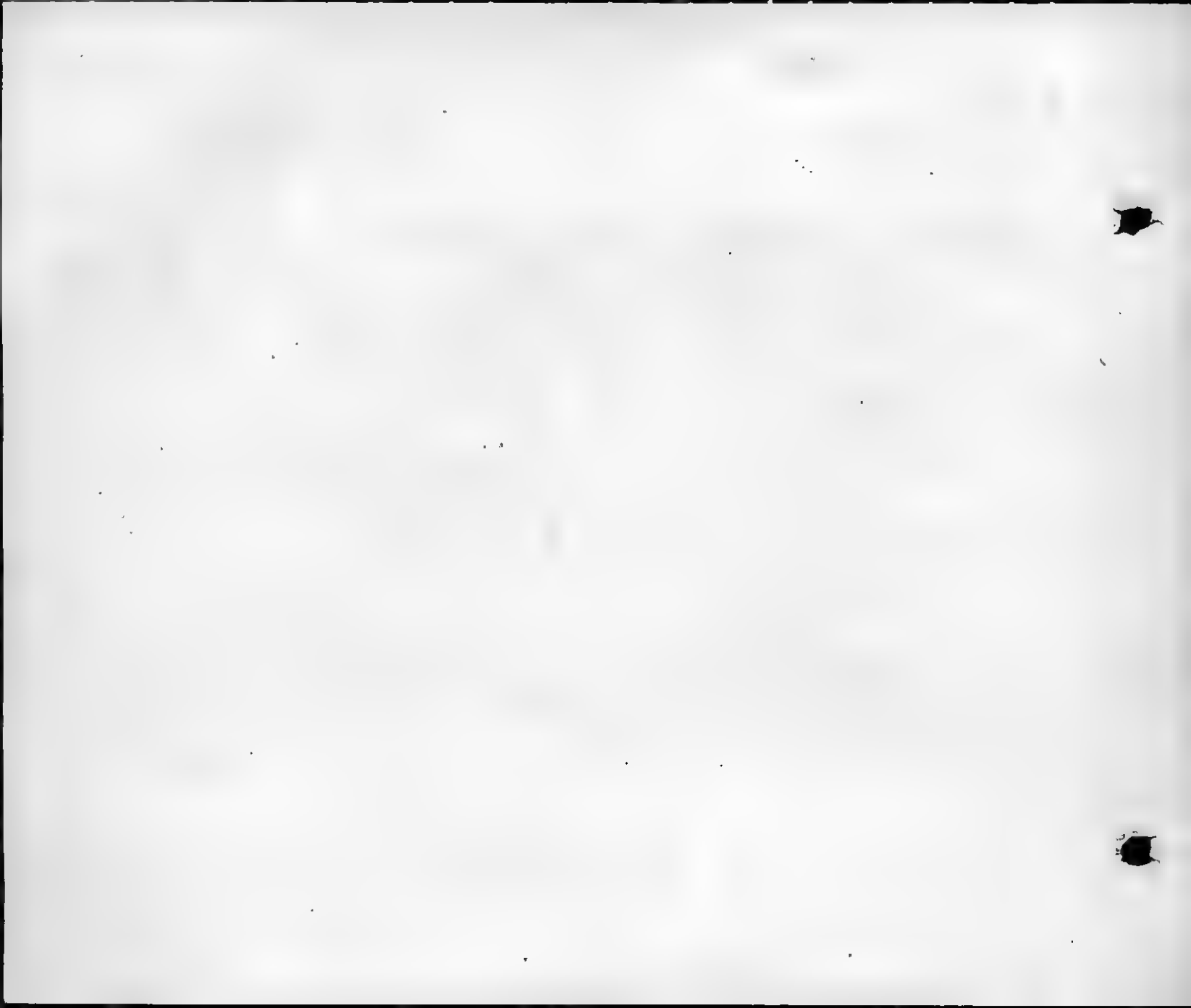
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3642 CERTIFICATE OF DEATH 036-7

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 14 Hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 d. STREET ADDRESS College Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JEANNETTE HENRIETTA RALSTON First Middle Last				4. DATE OF DEATH March 3 1961 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 4 1906	
9. AGE (in years last birthday) 54 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept Store		11. BIRTHPLACE (State or foreign country) Baltimore city Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Cook				14. MOTHER'S MAIDEN NAME Anna Unkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 315-22-8576		17. INFORMANT John J. Ralston Hagerstown Md. R # 3 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO carcinoma cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos 1 yr.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 1961 to Mar 3 1961 that (I) (we) last saw the deceased alive on Feb 6 1961 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE D. J. Boyer				22b. ADDRESS 3-3-61		22c. DATE SIGNED 3-3-61	
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE MAR 7 '61		25b. REGISTRAR'S SIGNATURE Orlando S. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3643

03658

1. PLACE OF DEATH a. COUNTY <u>W. shington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morrowood Church Home</u>				d. STREET ADDRESS <u>10x-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>May</u> Last <u>Remsberg</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/1866</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Mins. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John H. Remsberg</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Lighter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Noah Ed. Kefauver, Jr., Middletown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>Cerebral vascular acid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis gen</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>month</u> <u>yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hematoma of eye</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Explain nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>3/7</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Louis G. Graff</u> M.D.				22b. DATE SIGNED <u>3/10/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF M.D.</u>				22d. ADDRESS <u>119 E. Antietam</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/11/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cladhill Company, Middletown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION



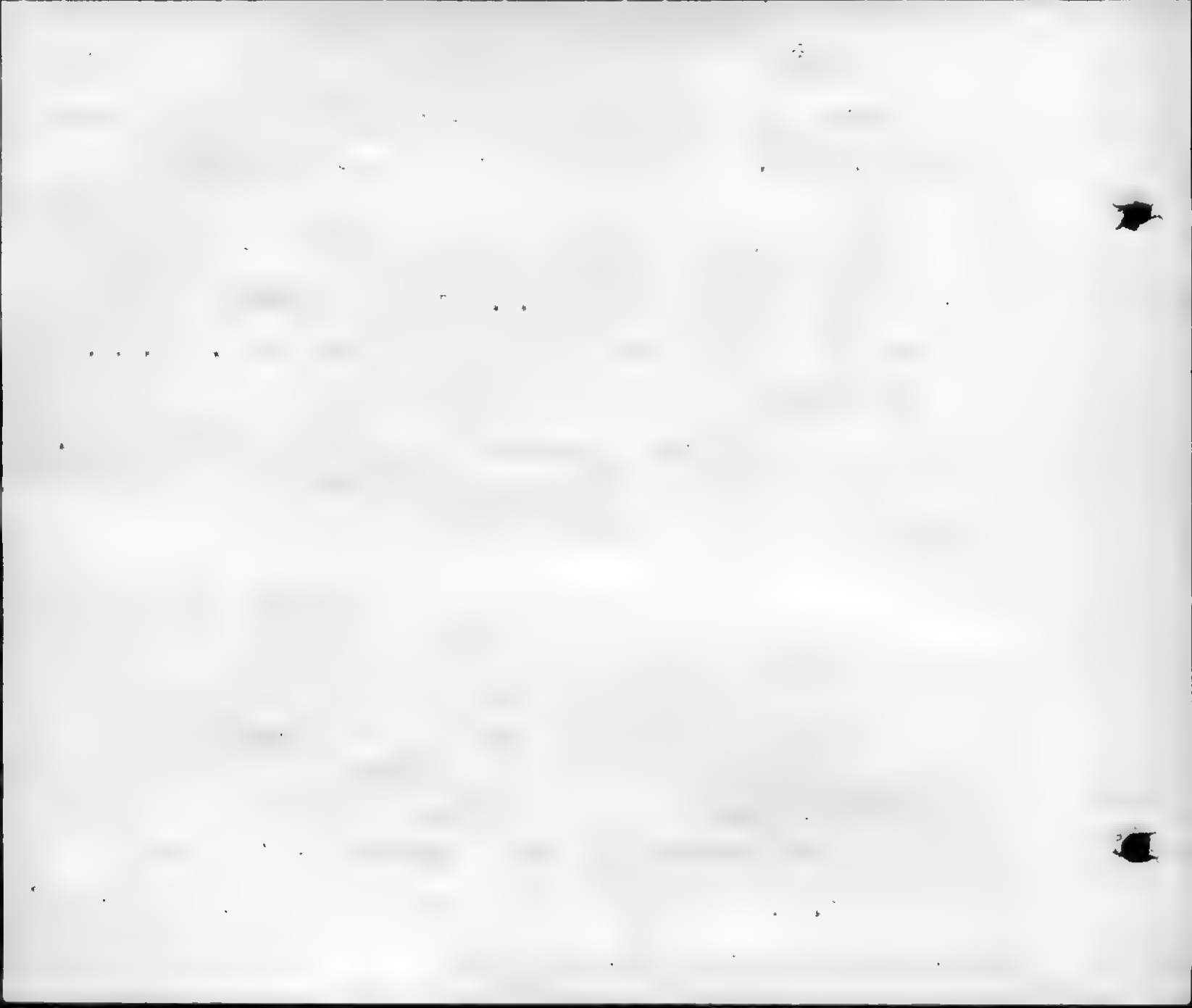
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3644

03633

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Hancock Md.				c. LENGTH OF STAY IN 1b 80 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Robinson			4. DATE OF DEATH Month 3 Day 27 Year 19 61				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.7.1871		9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months 3 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Bedford County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Russell Robinson Rural 2 Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Cerebral Hemorrhage secondary to arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/20/61 to 3/27/61 that (I) was last saw the deceased alive on 3/27/61 and that death occurred at 9:30 AM from the causes and on the date stated above							
22a. SIGNATURE L M Shaffer				22b. DATE SIGNED 3-29-61		22c. PHYSICIAN'S NAME (Type) L M SHAFFER MD	
22d. ADDRESS HANCOCK, MD				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3.30.61		23c. NAME OF CEMETERY OR CREMATORY Stone Brethern Cemetery Rural Hancock Washington		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hansel J. Stone Hancock Md				25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

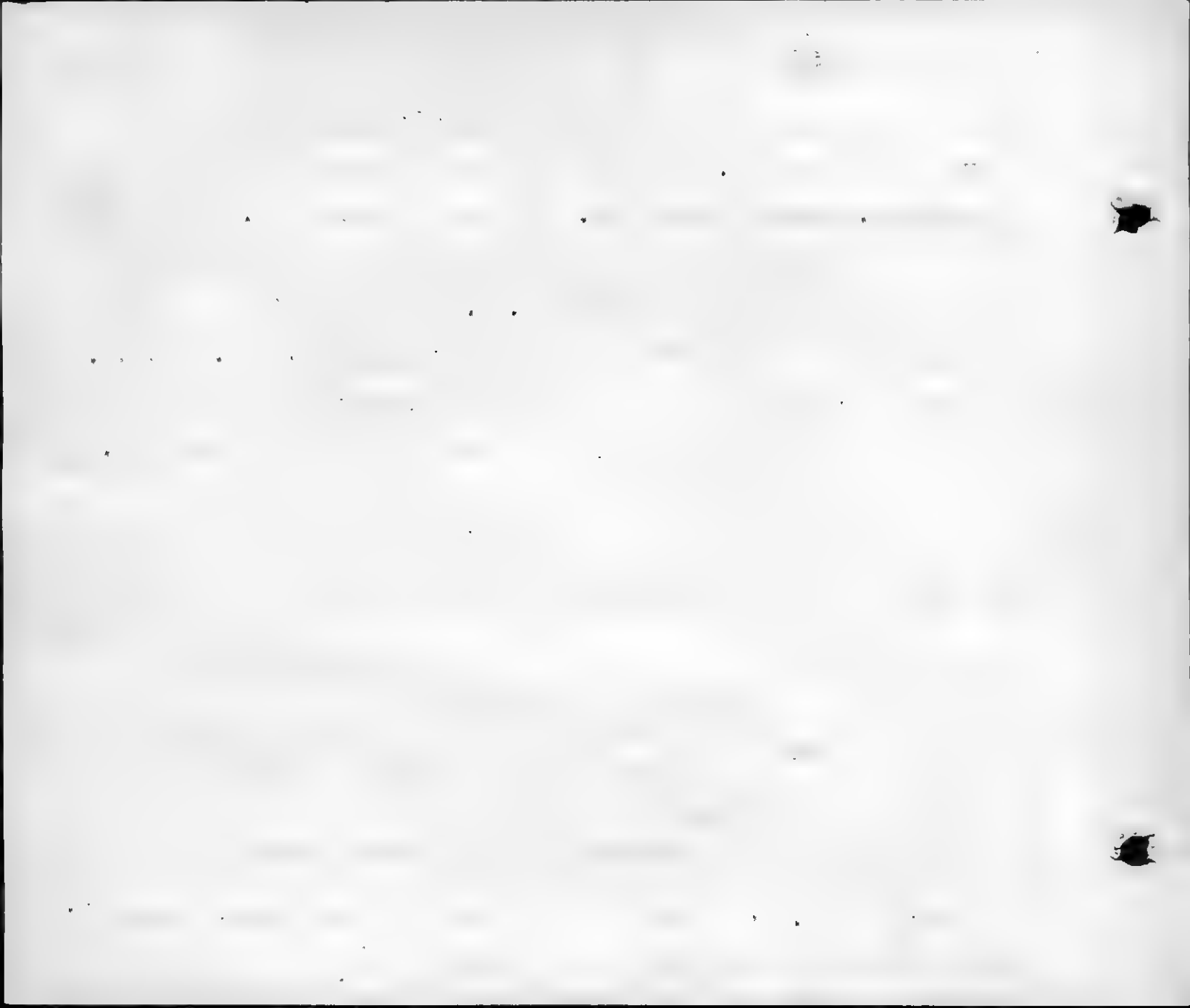
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VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3645 CERTIFICATE OF DEATH 03640

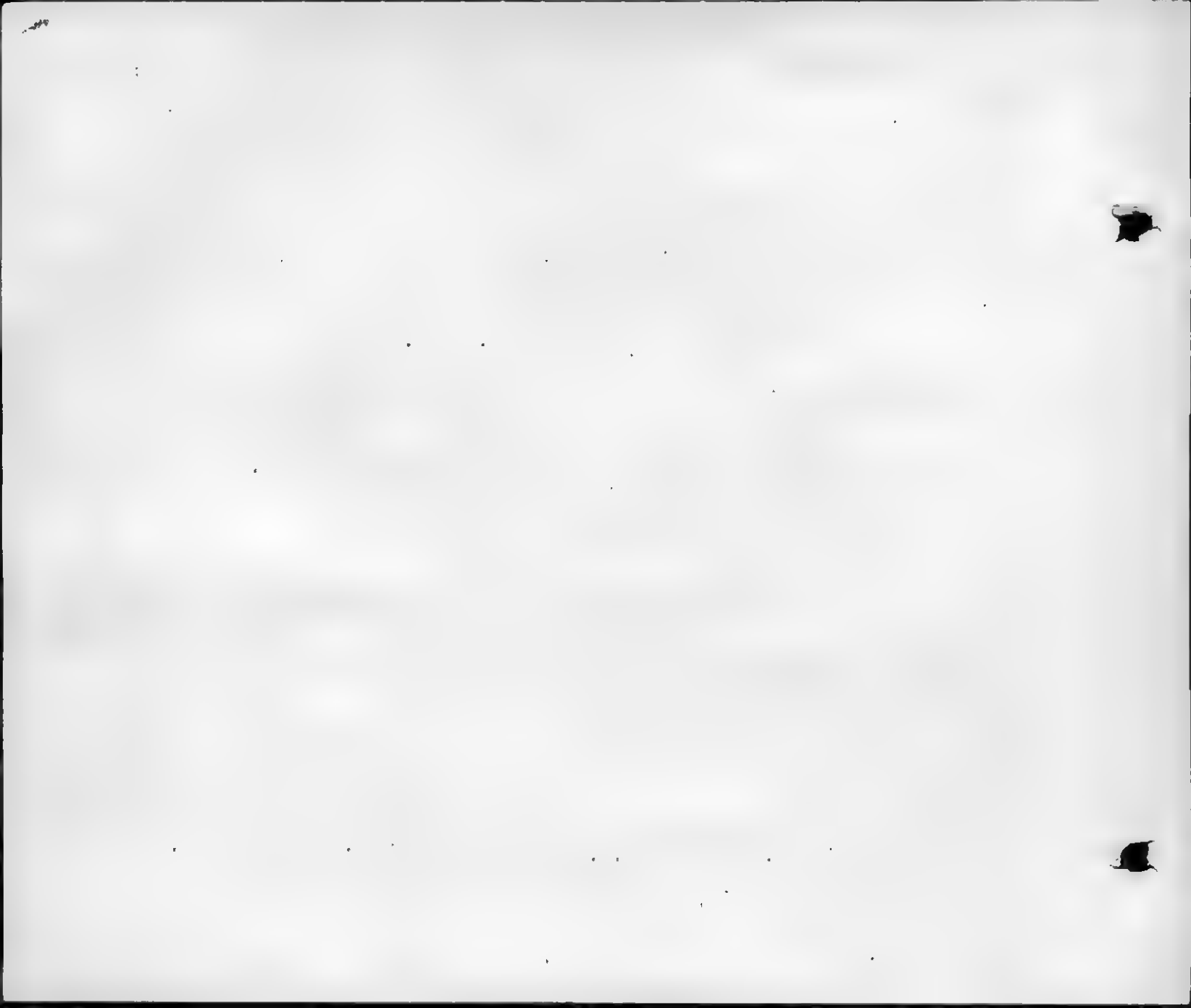
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rur Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock Maryland	
c. LENGTH OF STAY IN 1b 2 Days		d. STREET ADDRESS Rural 2 Hancock Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Chronic Disease Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE A. ROBINSON	First Middle Last	4. DATE OF DEATH MARCH 25 1961	Month Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.22.1877
9. AGE (In years last birthday) 83 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac A Younker		14. MOTHER'S MAIDEN NAME Mary C Hull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs Frank Eddy Rural 2 Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ABDOMINAL CARCINOMATOSIS DUE TO CARCINOMA OF THE PANCREAS (c) 4 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-23-1961 , to 3-25-1961 , that (I) lost saw the deceased alive on 3-25-1961 , and that death occurred at 1:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Antonio N. Pallagrosi M.D.		22b. DATE SIGNED 3-25-61	
22c. PHYSICIAN'S NAME (Type) ANTONIO N. PALLAGROSI		22d. ADDRESS 1500 PENNSYLVANIA AVE HAGERSTOWN Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3.29.61	23c. NAME OF CEMETERY OR CREMATORY Stone Bridge Brethern Rural Hancock Washington	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Houval & Stone Hagerstown Md.		25a. REC'D BY REGISTRAR MAR 29 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Week d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1133 Hamilton Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EVELYN WASKINS RUBEN				4. DATE OF DEATH Month Day Year March 26 1961 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feby 8 1907	
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore City Md		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore City Md	
13. FATHER'S NAME Kaulfman Waskins				14. MOTHER'S MAIDEN NAME Theresa Feinberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Aaron Ruben 1133 Hamilton Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Hemorrhage 170X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) Carcinoma - Breast - Metastatic				INTERVAL BETWEEN ONSET AND DEATH 7 days years. 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 23, 1956 to March 26, 1961 , that (I) (we) last saw the deceased alive on March 26, 1961 , and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE Philip J. Hirshman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 3/27/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/28/61		23c. NAME OF CEMETERY OR CREMATORY Bnai Abraham Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Washington Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR MAR 29 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

I



FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Item 18 Film 287 5-24-61 MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03642									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 25yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1715 Mountain Road rd.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) Jean		First Maire		Middle Kuss		Last Mar		4. DATE OF DEATH 13 1961	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 31 1934		9. AGE (In years last birthday) 26 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME James Banks		14. MOTHER'S M.A.DEN NAME Beatrice Weathers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 52-05-86996		17. INFORMANT Mrs. Beatrice Tate 459 Park Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 057.1 Meningococcemia? DUE TO Aspiration of vomitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary congestion and edema DUE TO Cerebral congestion and edema (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE [Signature]		M.D. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. D. D. Dittus, Jr.		Address (Street, city, town, or county)		DATE SIGNED 3-11-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Maryland			
23. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

no. 1000 400

Mem. L.H. Co. 7/1/01
25

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3648

03643

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 68 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 823 Spruce St.				d. STREET ADDRESS 823 Spruce St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary Middle Amanda Last Ruth		4. DATE OF DEATH		Month March Day 26 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1890		9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mercersburg, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William F. Bailey				14. MOTHER'S MAIDEN NAME Ida B. McCurdy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Jane Domenici Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cor pulmonale and 4.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary hypertension DUE TO (c) 3-5 yrs						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Bilateral lobar pneumonia ② Chas. myocardi						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 16 1961 to Mar 26 1961 , that (I) (we) last saw the deceased alive on Mar 24 1961 , and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Ditto III				22b. ADDRESS 217 West Washington St.		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Charles L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



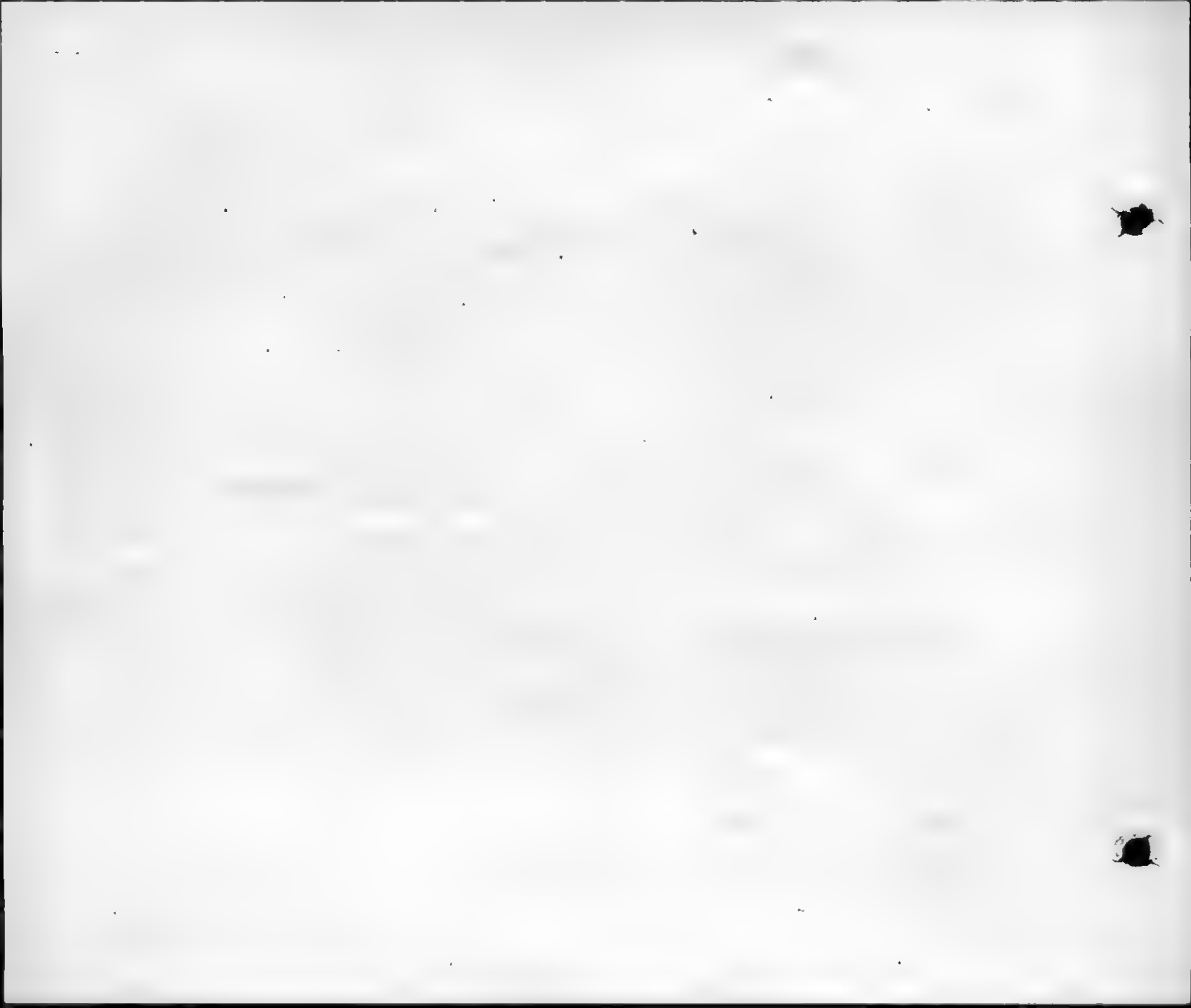
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3649 CERTIFICATE OF DEATH 03644

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 207 E. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First La Rue Middle Marie Last St. John		4. DATE OF DEATH Month March Day 4 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1925
9. AGE (In years last birthday) 35 yrs		10. IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.	11. IF UNDER 24 HRS. Months 35 Days 35 Hours 35 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY City Pool	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John J. St. John		14. MOTHER'S MAIDEN NAME Margie Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-20-2448	
17. INFORMANT Miss Mildred St. John Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident - left hemisphere DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO 260X (c) Diabetes mellitus PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years 20+ years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 6, 1961 to Mar 4, 1961 , that (I) (we) lost saw the deceased alive on Mar 4, 1961 , and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		3-7-61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Rest Haven Cemetery		Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. RECEIVED BY REGISTRAR MAR 8 1961	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hays	



TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

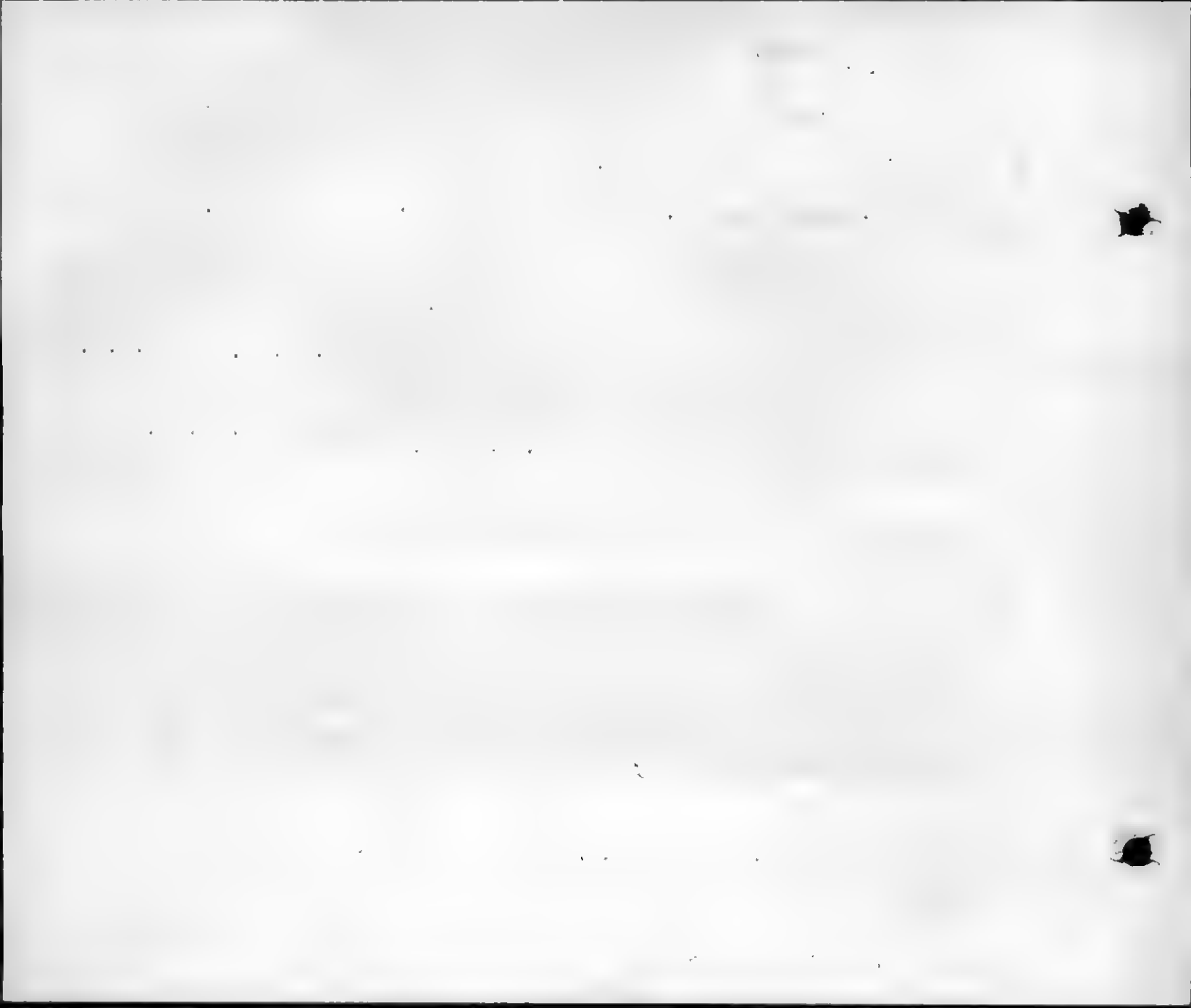
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3650

CERTIFICATE OF DEATH

03645

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1114 W. Washington St.				d. STREET ADDRESS 1114 W. Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Bell Schlotterbeck				4. DATE OF DEATH Month Day Year March 27 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1870	9. AGE (In years last birthday) 90 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kneisley				14. MOTHER'S MAIDEN NAME Adeline Cover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mary L. Donat 119 West Side Ave Hagerstown Wash. Co. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 427.0 DUE TO Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) Arteriosclerosis DUE TO Arteriosclerosis lying cause lost, (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1960 to March 27, 1961 , that (I) (we) last saw the deceased alive on March 26, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Philip J. Hirshman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 3/28/61			
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland					
23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/61	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR MAR 30 '61		25b. REGISTRAR'S SIGNATURE W. S. Kneale	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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3651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03646

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield				c. LENGTH OF STAY IN 1b 3 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highfield				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Liesbeth A. Sedlag				4. DATE OF DEATH Month Day Year March 28, 1961			
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH 1/28/1908	
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY			
11 BIRTHPLACE (State or foreign country) Breslau, Germany				12. CITIZEN OF WHAT COUNTRY? Germany			
13. FATHER'S NAME Adolph Hirsch				14. MOTHER'S MAIDEN NAME Anna Kalinke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Thadius A. Calimer, Highfield Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from Feb 1, 1961 to Mar 28, 1961, that (I) (we) last saw the deceased alive on Mar 28, 1961, and that death occurred at 11 PM, from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Kiefer M.D.				22b. DATE SIGNED 29 May 61			
22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer				22d. ADDRESS Blue Ridge Summit, Pa			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City, town, or county) (State) Lantz #1, Frederick Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR APR 3 '61			
ADDRESS				25b. REGISTRAR'S SIGNATURE Charles L. Thomas			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3652

03647

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 weeks		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 5 Sanford Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) E. LIZABETH ROESSNER SHANK First Middle Last				4. DATE OF DEATH Month 3 Day 2 Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1908		9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Frank Roessner				14. MOTHER'S MAIDEN NAME Vinona Thum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) none		17. INFORMANT C. Robert Shank, Catonsville, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of palate and Nasopharynx 194.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH 20 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1960 to March 2, 1961 , that (I) was last saw the deceased alive on March 2, 1961 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun		22b. DATE March 2, 1961		22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-4-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Md. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

(M)

(1)

212122-23 1 1 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

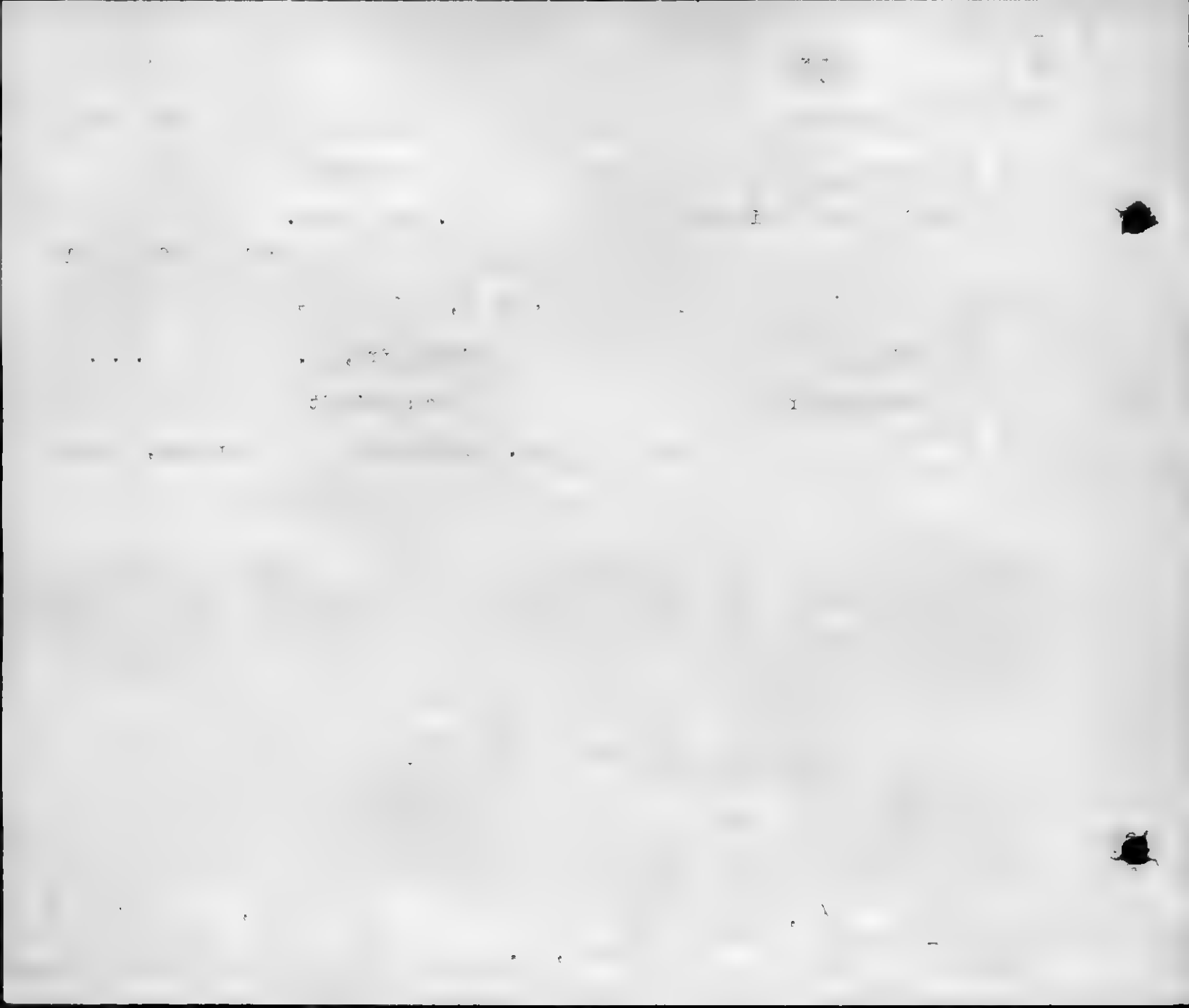
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3653

03648

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 80 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if installed on: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 144 E. Lincoln Ave.	
3. NAME OF DECEASED (Type or print) SUSAN DELLA SHRODER		4. DATE OF DEATH March 26 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1873	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 4 IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Shippensburg, Pa.	
13. FATHER'S NAME Edward Keefer		14. MOTHER'S MAIDEN NAME Frances Shillito	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Virginia Cook		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with myocardial infarct 42000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Branch Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 55 19 to 26 Mar 19 61 that (I) (we) last saw the deceased alive on 25 Mar 19 61 , and that the death occurred at 24 Mar from the causes and on the date stated above.			
22a. SIGNATURE F. F. Lusby		22b. DATE SIGNED 27 Mar 61	
22c. PHYSICIAN'S NAME (Type) F. F. Lusby		22d. ADDRESS 2301 Potomac	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29, 1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25a. REC'D BY REGISTRAR APB 3 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3654

CERTIFICATE OF DEATH

Reg. Dist. No.

03649

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 2</u>				e. STREET ADDRESS <u>Route 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Catherine</u> Last <u>Sister</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1901</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>61</u>	IF UNDER 24 HRS. Hours <u>61</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Staunton Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Tisdale, (Bertie Jane)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Henry Sister</u> Address <u>Same as deceased</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c) <u>331X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed tuberculosis. Bronchiectasis of left lung.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>July</u> Day <u>19</u> Year <u>1958</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>61</u> , and that death occurred at <u>10:35</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>28 W. Potomac St. Williamsport, Md.</u>							
DATE SIGNED <u>March 20, 1961</u>							
ACTUAL SIGNATURE <u>Alice N. Cunningham M.D.</u> (Covered for Dr. Byrkit while on vacation)							
PHYSICIAN'S NAME (Type) <u>Alice N. Cunningham M.D.</u> & <u>Dr. Max Byrkit</u> 28 W. Potomac St. Williamsport, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Thomas</u>	

Wm. C. Kott



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3655

03650

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 39 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 7 W. Wilson Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle EVELYN Last SLUSER		4. DATE OF DEATH Month March Day 25 Year 19 61	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 15, 1893 9. AGE (in years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 67 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sperryville, Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry A. Brown		14. MOTHER'S MAIDEN NAME Elmira Woodard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war and dates of service)		16. SOCIAL SECURITY NO. 220-18-1125 17. INFORMANT Mr. Harry E. Slusher Hagerstown, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular Disease DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 10 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6/53 , 19....., to 3/25/61 , 19....., that (I) (we) last saw the deceased alive on 3/25/61 , 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE SEARL YOUNG		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) SEARL YOUNG		22d. ADDRESS 148 W. Potomac Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/28/1961	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Rouzer ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE 3/27/61 25b. REGISTRAR'S SIGNATURE C. E. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

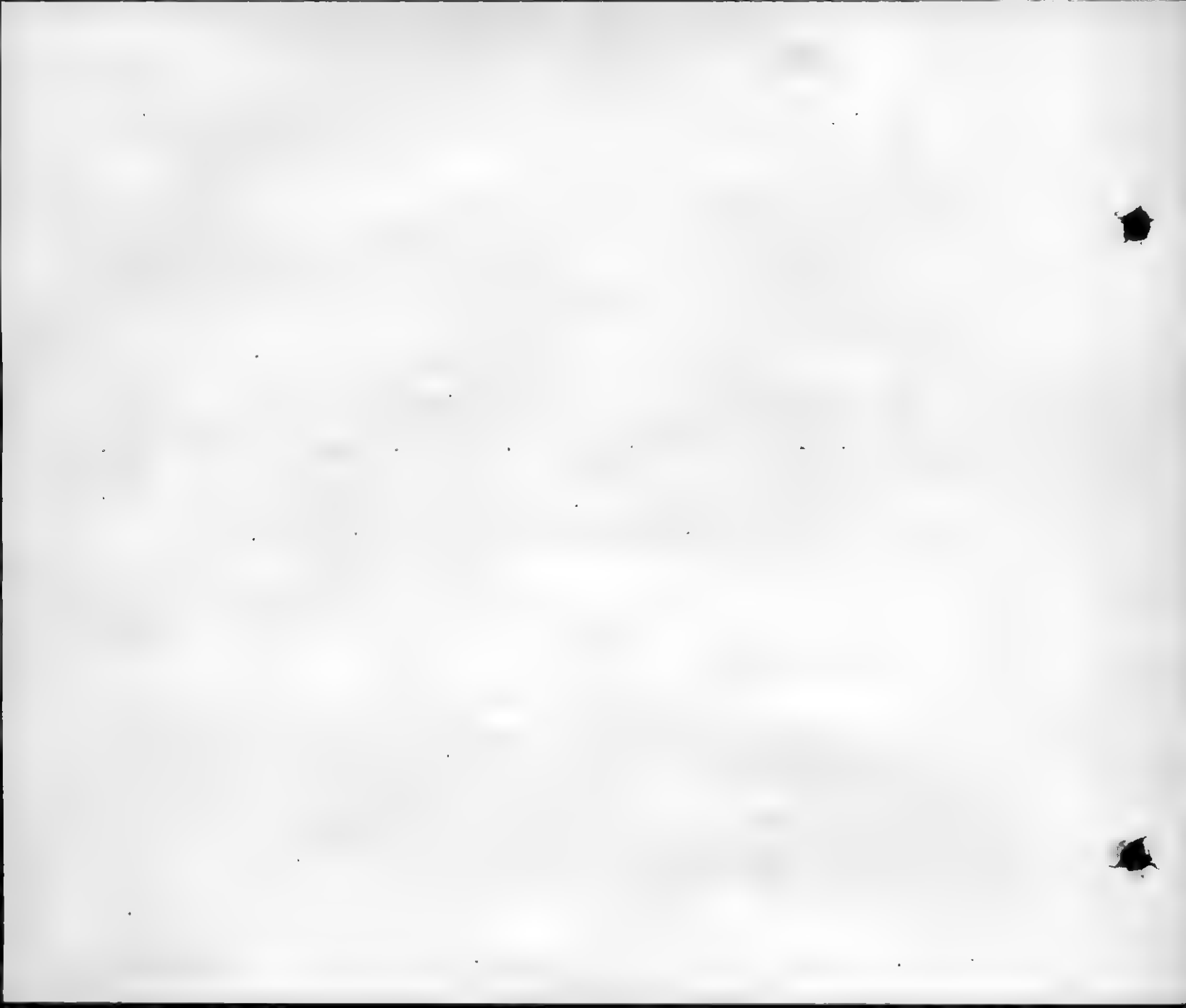
3656

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03651

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Cavetown	
3. NAME OF DECEASED (Type or print) George Omer Smith		4. DATE OF DEATH Month March Day 1 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Smithsburg, d.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Luther Smith		14. MOTHER'S MAIDEN NAME Beadie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO W. W. 1 222-10-3530	
17. INFORMANT Mrs. Nada B. Smith		Address Cavetown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE +43X DUE TO HYPERTENSIVE CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIO-VASCULAR DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 , to March 1, 1961 , that (I) (we) last saw the deceased alive on MARCH 1, 1961 , and that death occurred at 2:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE E. R. LADDIZADAL		22b. DATE 3-1-61	
22c. PHYSICIAN'S NAME (Type) E. R. LADDIZADAL		22d. ADDRESS Smithsburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-4-61	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown, md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Smithsburg, Md.	
25a. REC'D BY REGISTRAR DATE MAR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3657

CERTIFICATE OF DEATH

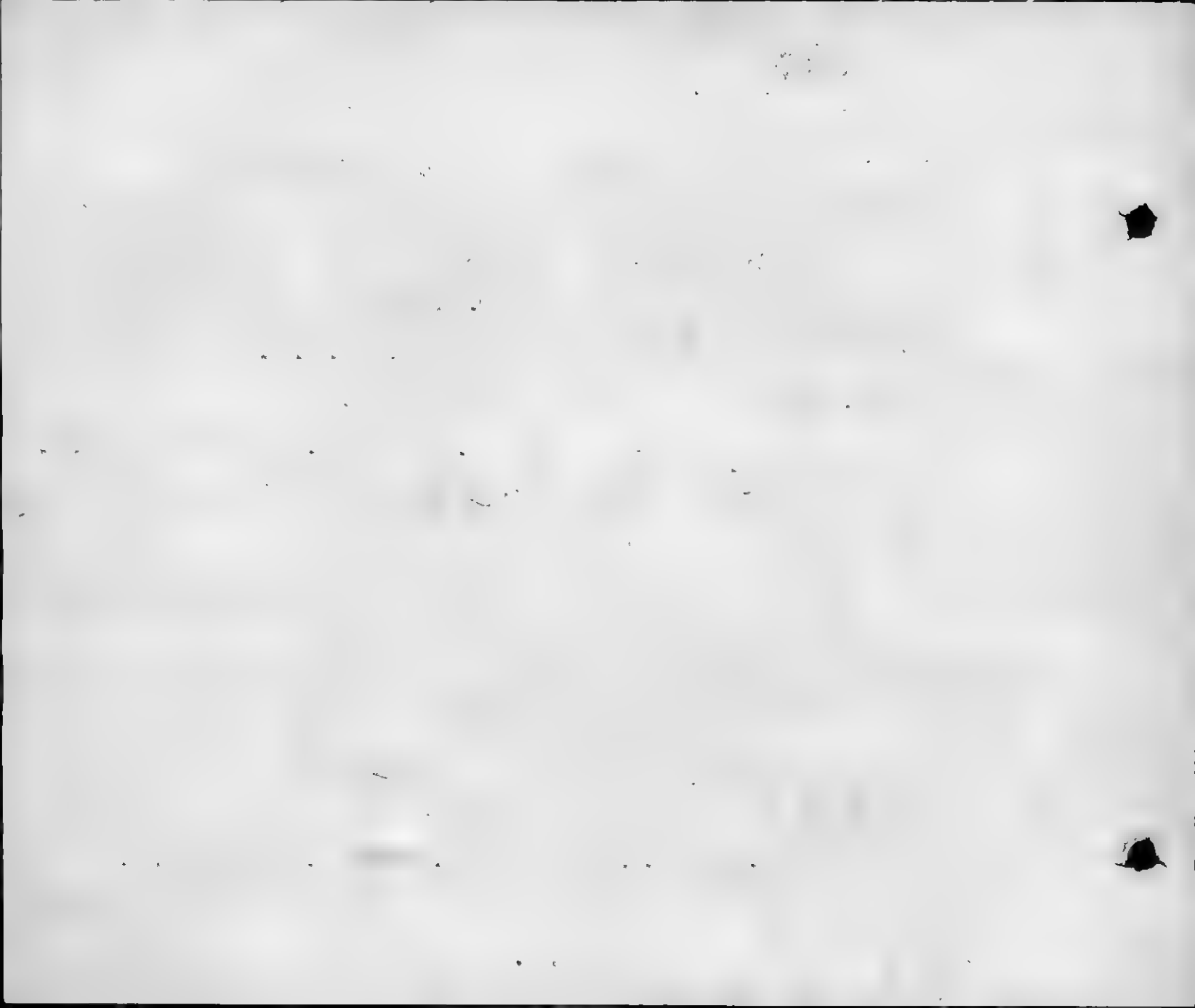
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u> c. LENGTH OF STAY IN 1b <u>Most of life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 1</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u> d. STREET ADDRESS <u>R # 1</u>			
3. NAME OF DECEASED (Type or print) <u>Nellie Gertrude Snodderly</u>				4. DATE OF DEATH <u>March 22 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Cedar Lawn, Wash. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry C. Rummel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Ewey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Walter C. Snodderly Sr.</u>				18. ADDRESS <u>R # 1 Williamsport, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Ac: myocardial infarction</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year <u>3/22/61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u> </u> 20f. (City or town) <u>Williamsport</u> (County) <u>Washington</u> (State) <u>Md.</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/61</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>3/22/61</u> 19 <u> </u> , and that death occurred <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u> M.D.				22b. DATE SIGNED <u>3/22/61</u>			
22c. PHYSICIAN'S NAME (Type or print) <u>Ralph F. Young M.D.</u>				22d. ADDRESS <u>101 E. Potomac St. Williamsport, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Wm. A. Horst</u>			
25b. REGISTRAR'S SIGNATURE <u>Wm. A. Horst</u>				DATE <u>MAR 27 '61</u>			

VII A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

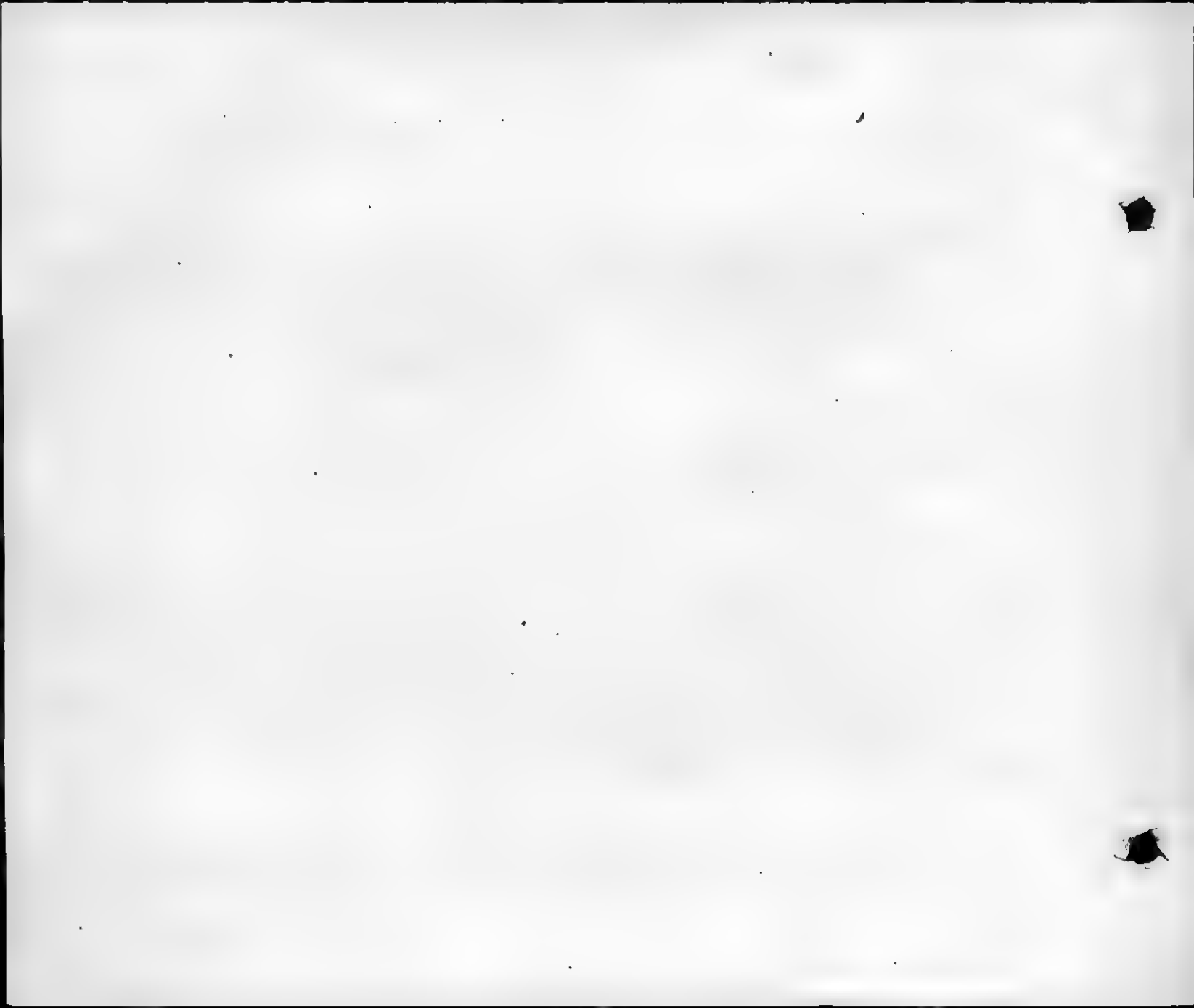
3658

CERTIFICATE OF DEATH

03653

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORBIN HOLLINGSWORTH SNYDER</u>				4. DATE OF DEATH Month Day Year <u>March 31 1961 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Hagerstown Wash Co. Ltd.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Elna Hendenhall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>311-09-1936</u>		17. INFORMANT Address <u>Mrs Pearl Jullenix 873 Virginia Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastric Sclerotic Heart Dis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured wrist (left)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Mar 14, 1961</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1959</u> to <u>Mar 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 22, 1961</u> , and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>David R. Brewer</u>				22b. DATE SIGNED <u>3/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>	
22d. ADDRESS <u>Clear Spring Md.</u>				22e. REC'D BY REGISTRAR <u>MAR 28 '61</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery near Clear Spring Wash Co. Ltd.</u>		23d. LOCATION (City, town, or county) (State) <u>Clear Spring Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Corbin Hagerstown Md.</u>				25. ADDRESS <u>Clear Spring Md.</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3659

CERTIFICATE OF DEATH

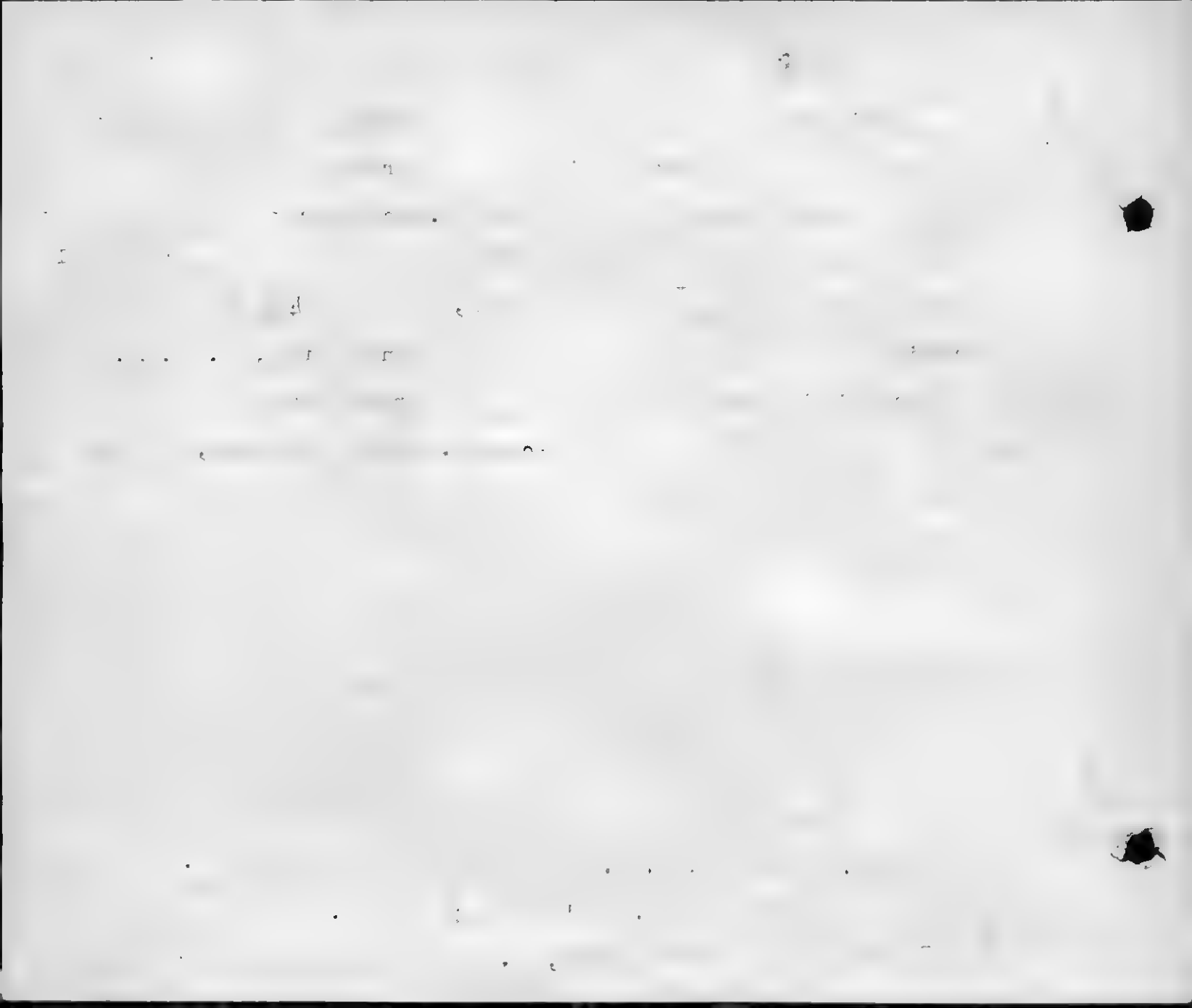
03654

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY in lb most of life		d. STREET ADDRESS 525 N. Locust Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIE VIOLET SNYDER		4. DATE OF DEATH Month March Day 10 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Clearspring District, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George William Bloyer		14. MOTHER'S MAIDEN NAME Charlotte Wishard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph C. Snyder		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) general arteriosclerosis and (a), stating the underlying cause last. (c) arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 24, 1960 to May 10, 1961 , that (I) (we) last saw the deceased alive on May 10, 1961 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED 3/11/61	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.		22d. ADDRESS 217 West Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/1961	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	23d. LOCATION (City, town or county) (State) St. Paul's Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25a. REC'D BY REGISTRAR DATE MAR 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3660

03655

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE Md. b. COUNTY Wash.	
c. LENGTH OF STAY IN 1b 32 years		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1410 Oak Hill Avenue		d. STREET ADDRESS 1410 Oak Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roy Middle Miller Last Snyder		4. DATE OF DEATH Month March Day 17 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) vice-president		10b. KIND OF BUSINESS OR INDUSTRY building supplies	
11. BIRTHPLACE (State or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George E. Snyder		14. MOTHER'S MAIDEN NAME Fannie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 214-09-8881	
17. INFORMANT Helen P. Snyder, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder 181- Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 9 1959 to March 17 1961 that (I) (we) last saw the deceased alive on March 15 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. ADDRESS 148 West Washington Street Hagerstown, Maryland	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-19-61	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City, town, or county) (State) Waynesboro, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

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3661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

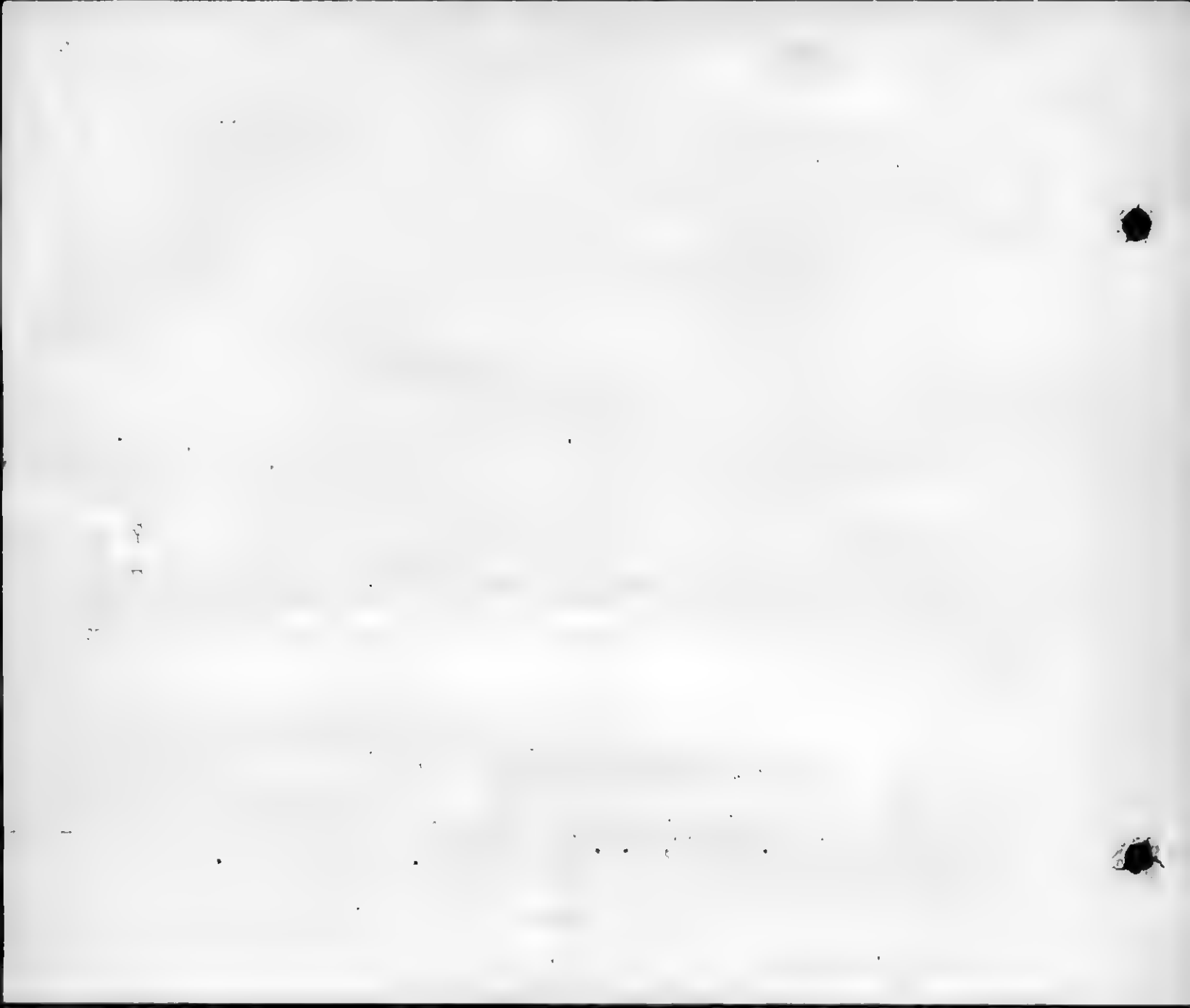
CERTIFICATE OF DEATH

03657

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>1 127 East Antietam St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL ANGLE SPICKLER</u>				4. DATE OF DEATH Month Day Year <u>March 24 1961 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed Brokering Wash Co Ind</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alvey Spickler</u>				14. MOTHER'S MAIDEN NAME <u>Elva Angle</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>214-091-1061</u>		17. INFORMANT Address <u>Mrs Norma V. Spickler 127 E. Antietam St Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Non hemolytic Streptococci bacteria</u>							INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>3 days</u> <u>3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Malnutrition self imposed arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 21 1961</u> to <u>Mar 24 1961</u> , that (I) <u>(X)</u> last saw the deceased alive on <u>Mar 24 1961</u> , and that death occurred at <u>7p M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis G. Graff, M.D.</u>		22b. DATE SIGNED <u>3-25-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>		22d. ADDRESS <u>119 E. Antietam St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Ind</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 29 61</u>		25b. REGISTRAR'S SIGNATURE <u>Wm B. Thoms</u>	

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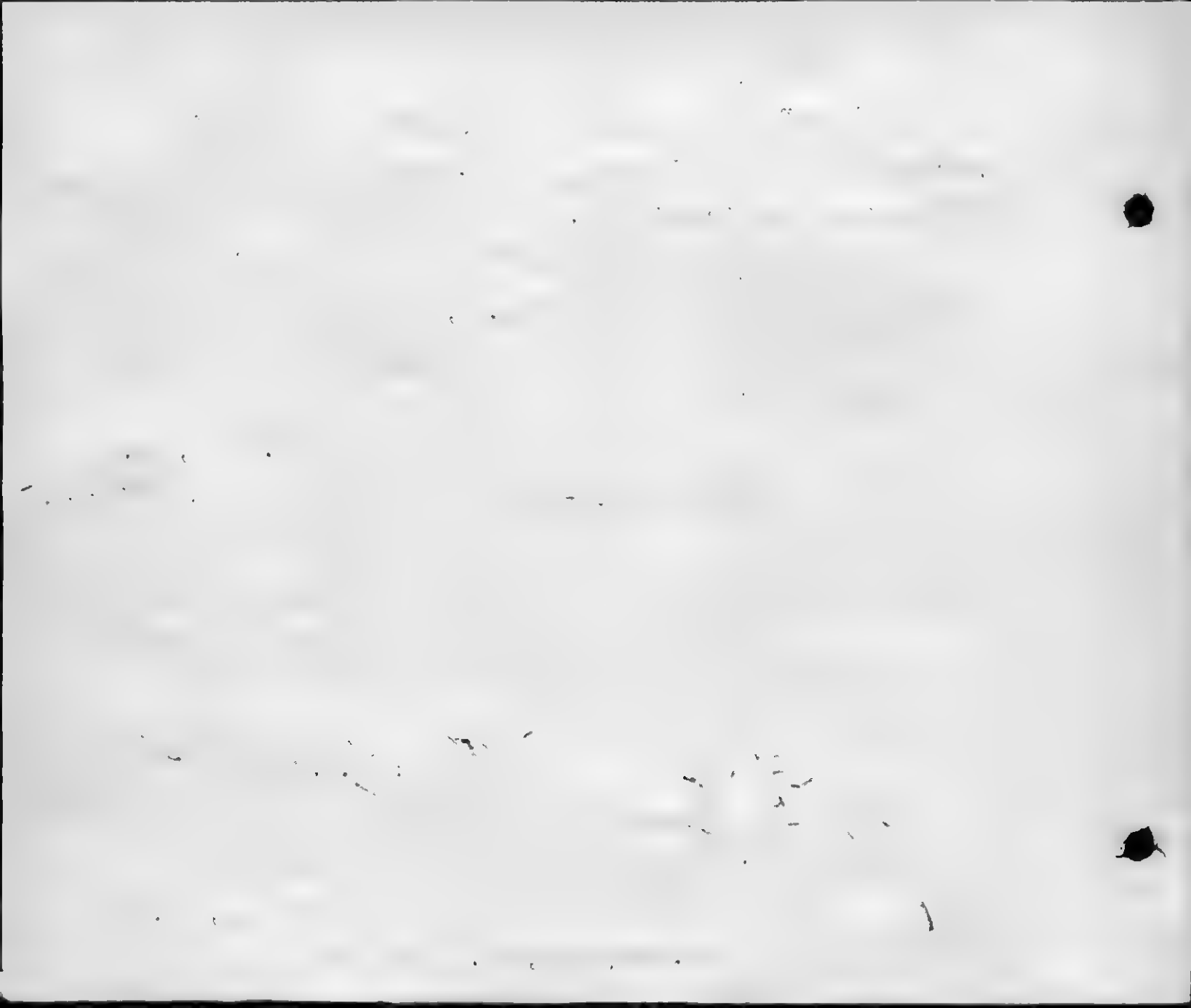


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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3662
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03656

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Nursing Home Virginia Ave. 1222</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. James</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Aleatha Pearl Sperow</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aaron Cushwa Middlekauff</u>			14. MOTHER'S MAIDEN NAME <u>Laura Eakle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clarence Sperow</u> Address <u>St. James, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial dysfunction in the heart</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/15/61</u> to <u>3/15/61</u> that (I) (we) last saw the deceased alive on <u>4/15/61</u> and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u> M.D.				22b. DATE SIGNED <u>3/15/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young</u>				22d. ADDRESS <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bakersville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Liof</u>				25a. REC'D BY REGISTRAR <u>Williamsport, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SMITHSBURG</u> <u>RURAL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>SMITHSBURG RT. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NRTTIE</u> Middle <u>JULIA</u> Last <u>STEVENS</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>19 61</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10/27/1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>12</u> Min. <u>15</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>8</u> Hours <u>12</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM HENRY DENNIS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SNIVELY STRITE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. LAUREN STEVENS</u> <u>BIG SPRING MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Atherosclerosis, Severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>Recent</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. T. V. Ditto, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. T. V. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-13-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Norman Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this form, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

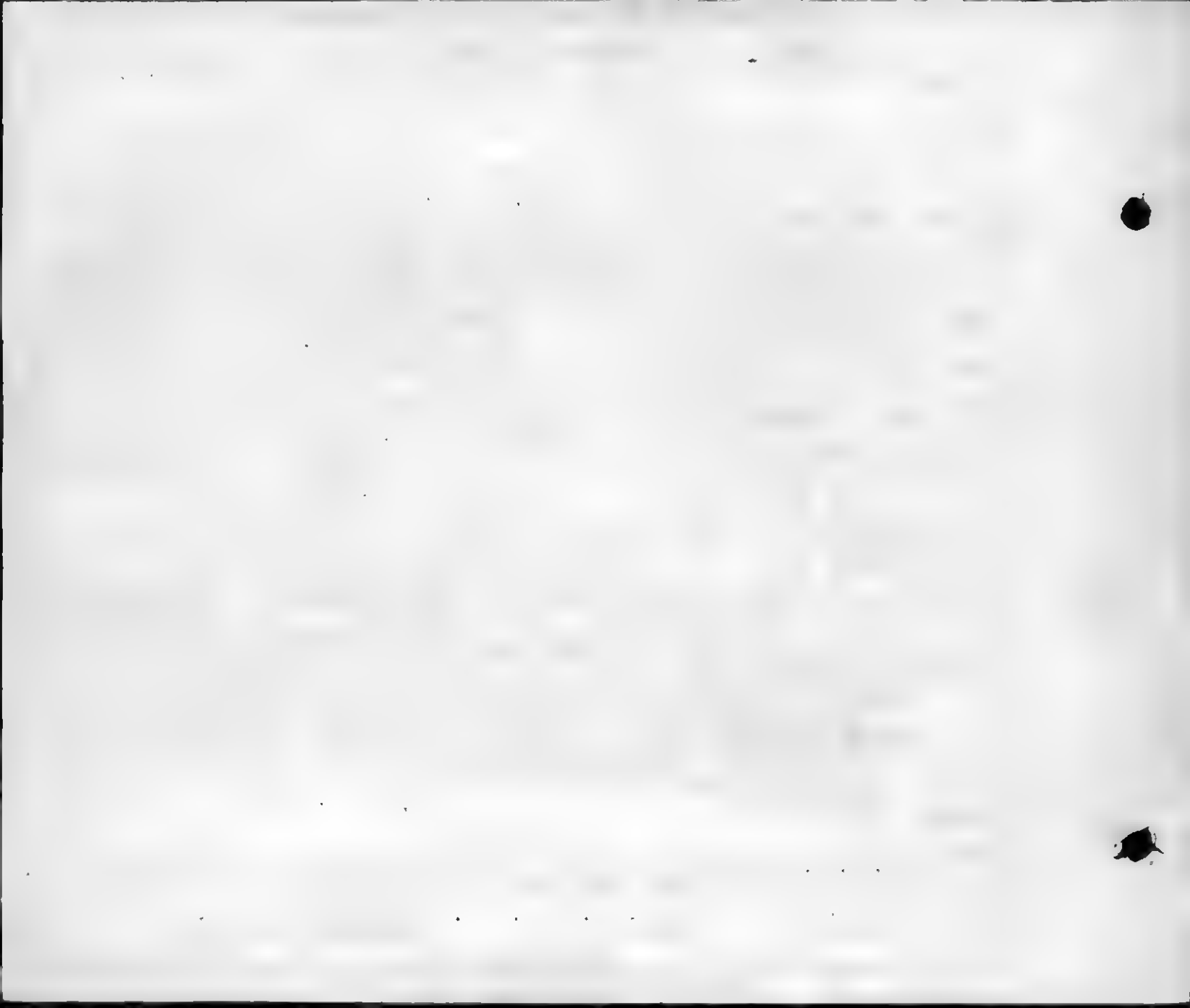
3664

CERTIFICATE OF DEATH

Reg. Dist. No.

03653

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>20 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1108 Reservoir Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Albert</u> Last <u>Stearns</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/61</u>	
9. AGE (In years last birthday) <u>20 yrs.</u>		IF UNDER 1 YEAR Months <u>30</u> Days <u>20</u> Hours <u>30</u> Min. <u>30</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Albert Stearns</u>				14. MOTHER'S MAIDEN NAME <u>Lillian J. Stearns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>H. D. Bowman</u>		Address <u>1108 Reservoir Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypaline Membrane</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>premature birth</u> DUE TO <u>1</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>61</u> , to <u>3/6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>61</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. D. Bowman</u>				M.D. <u>3/8/61</u> <u>H. D. Bowman</u> DATE SIGNED <u>3/7/61</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. D. Bowman</u>				ADDRESS (Street, city or town, state) <u>318 North Potomac Street, Hagerstown, Md.</u>			
22a. BY WHOM CREMATION, BURIAL, OR INTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>3/15/61</u>		<u>Wash. Co. Hosp. Lab.</u>		<u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Schaffer, Adm.</u>				24a. REC'D BY REGISTRAR <u>Wash. Co. Hospital</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

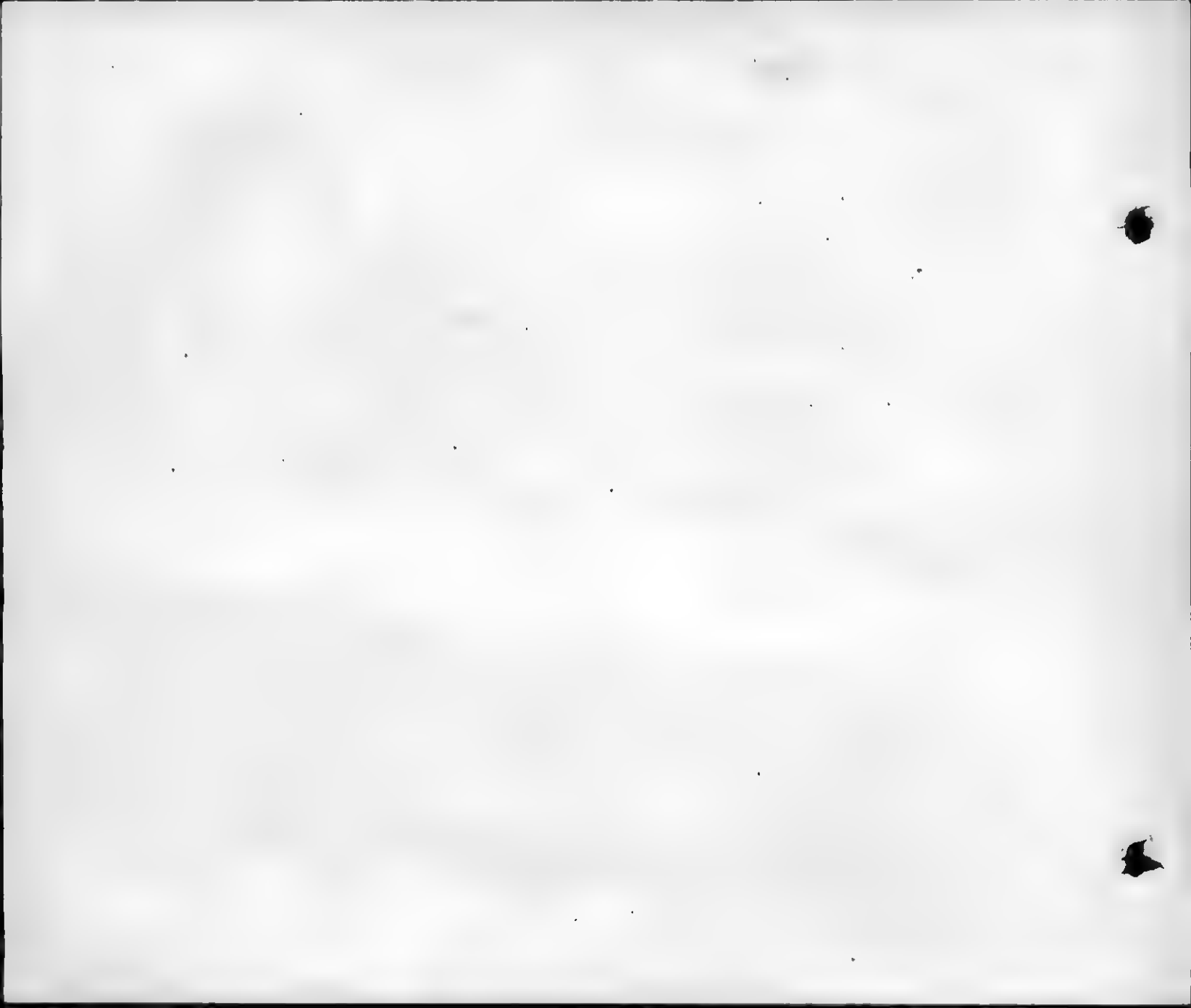


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3665

03660

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md State Hosp		e. STREET ADDRESS 310 Bryan Place	
3. NAME OF DECEASED (Type or print) First Ima Middle Dwila Last STOTLER		4. DATE OF DEATH Month 3 Day 31 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14 1888
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 5 Days 3 Hours 1 Min.	11. IF UNDER 24 HRS Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Stotler		14. MOTHER'S MAIDEN NAME Rutie Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Daniel D. Stotler		Address 147 Bellview Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma of right ankle, with widespread metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 years + 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 23 1960 to March 31 1961 , that (I) two last saw the deceased alive on March 31 1961 , and that death occurred at 6:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. ADDRESS 1500 Penna Ave Hagerstown, Md	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/3/61	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 3 1961	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur L. House	



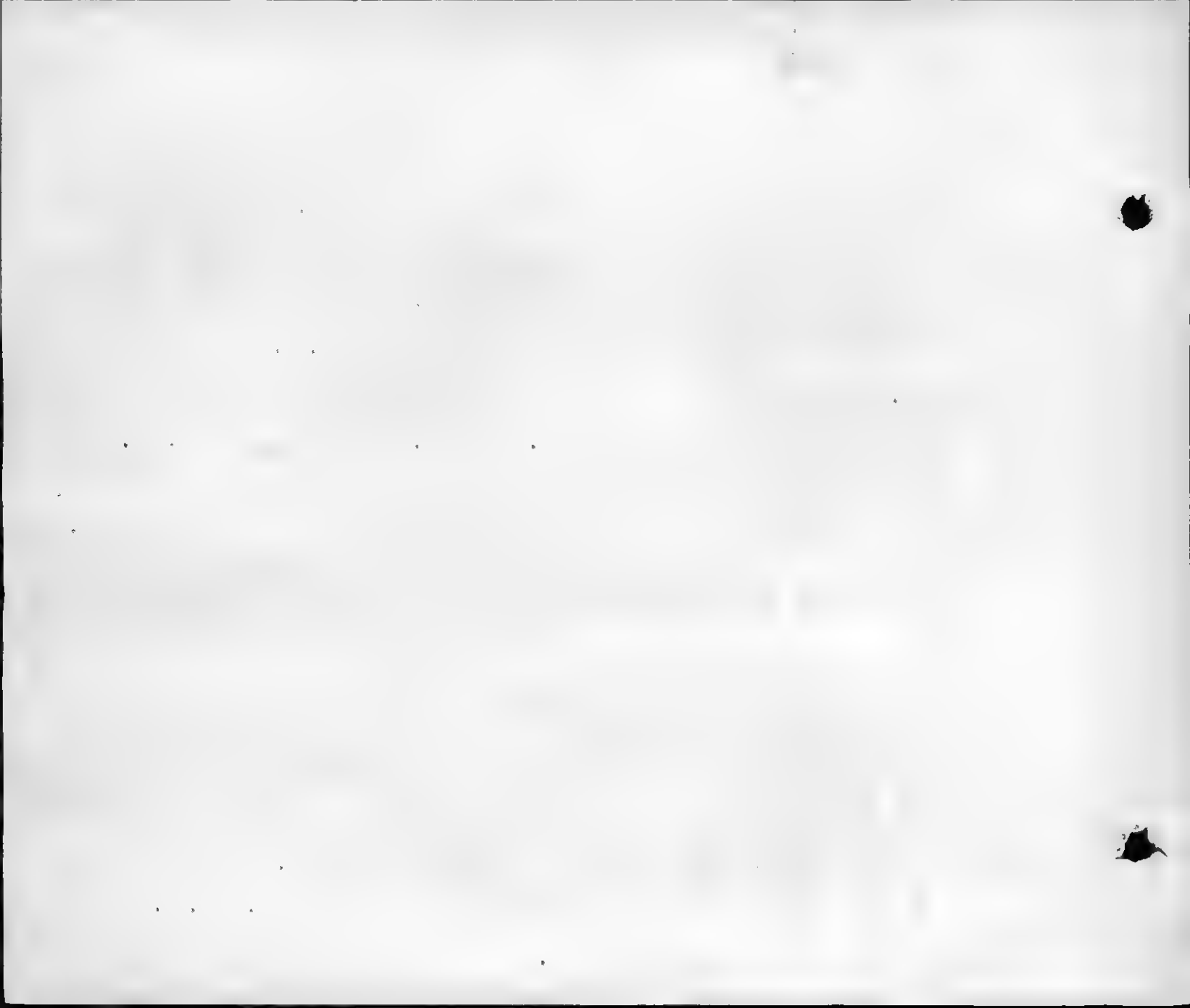
may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
3666
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0366

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle May Last Trumpower				4. DATE OF DEATH Month March Day 18 Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1882	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		11. IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min.		12. IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Smithsburg, Md. R.D.2			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Cyrus B. Bachtell				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Suter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mrs. Robert N. Bachtell Hagerstown, Md.			
17. INFORMANT Mrs. Robert N. Bachtell Hagerstown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							
DUE TO Auricular Fibrillation							
DUE TO Arteriosclerotic Cardiovascular Disease							
INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 Yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3-18 1961 to 3-19 1961 , that (I) (we) last saw the deceased alive on 3-18 1961 and that death occurred at 4:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 3-19-61							
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D. 22d. ADDRESS Smithsburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF 3/21/61							
23c. NAME OF CEMETERY OR CREMATORY Stouffers Cemetery							
23d. LOCATION (City, town, or county) (State) Smithsburg, Md. R.D.2							
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove ADDRESS Waynesboro, Pa.							
25a. REC'D BY REGISTRAR MAR 22 '61							
25b. REGISTRAR'S SIGNATURE Clifton S. House							

MEDICAL CERTIFICATION



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

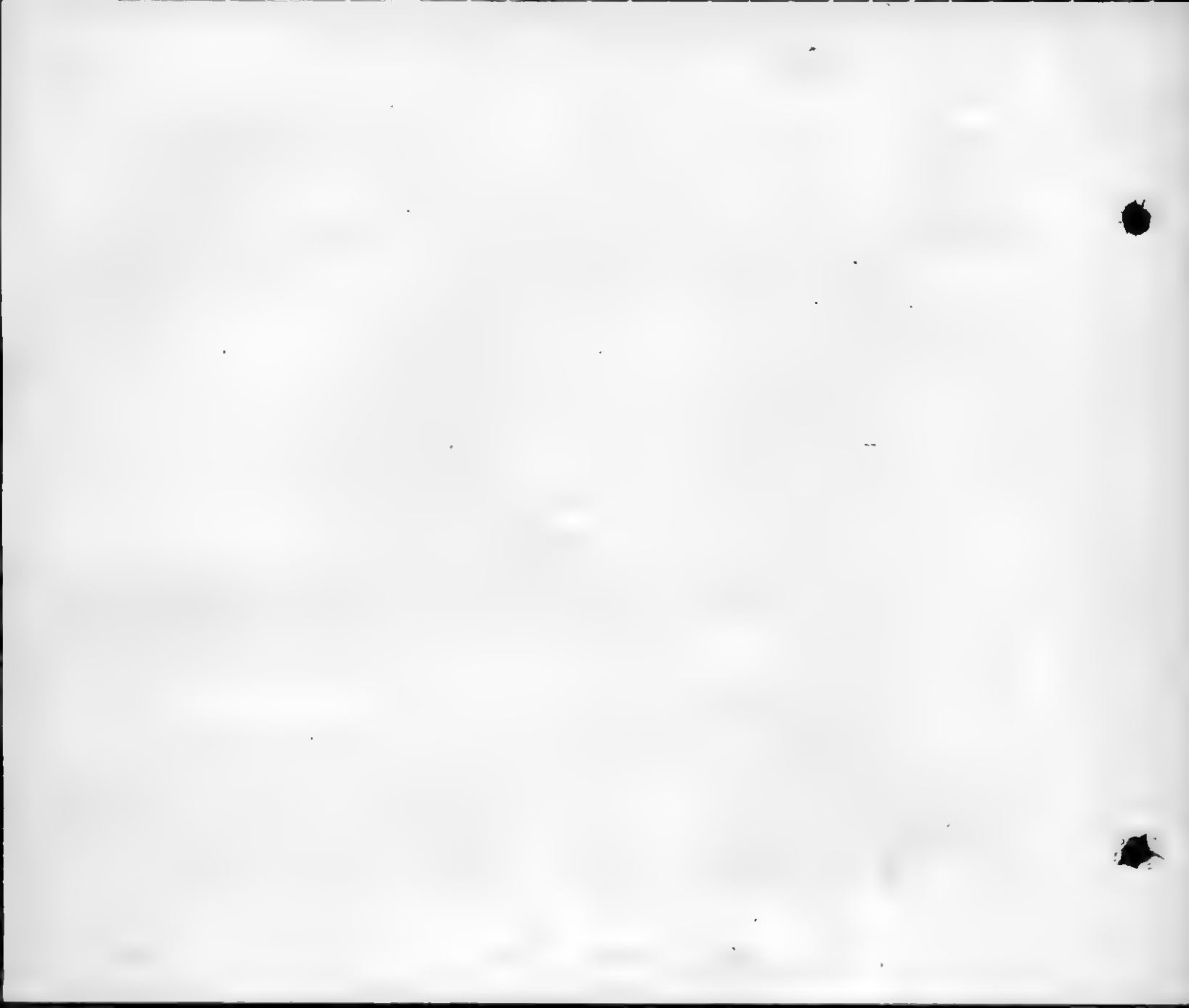
3667

CERTIFICATE OF DEATH

302

03662

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
f. STREET ADDRESS <u>1901 West Washington St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>ELLEN</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>21</u>	11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Renner</u>		14. MOTHER'S MAIDEN NAME <u>Lay Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>James R. Turner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>151X</u> DUE TO <u>Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>21 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/14 1959</u> to <u>3/30 1961</u> , that (I) (we) last saw the deceased alive on <u>3/28 1961</u> , and that death occurred at <u>p. m.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>George Jennings</u>		22b. DATE SIGNED <u>4/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>		22d. ADDRESS <u>Hagerstown, Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 2, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>APR 3 '61</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Haines</u>	

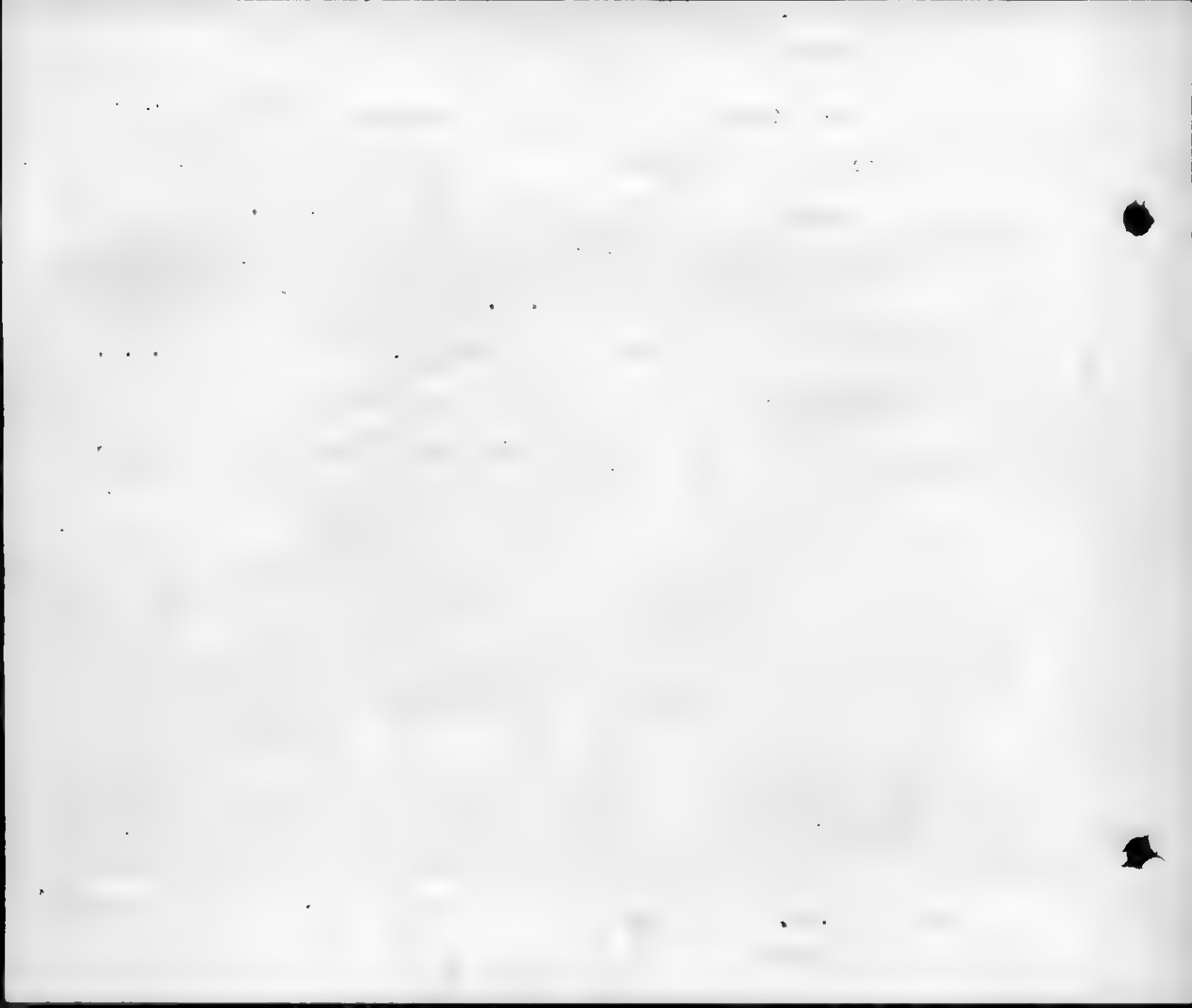


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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3668
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03663

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. STREET ADDRESS Rural 2 Hancock Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Orville Last Weller				4. DATE OF DEATH Month 3 Day 8 Year 19 61			
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7.25.1927		9 AGE (n years last birthday) 33 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon Weller				14. MOTHER'S MAIDEN NAME Iva Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Vernon Weller Rural 2 Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Embolism DUE TO (b) Rheumatic Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Had heart surgery 5 yrs. ago INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961 to Mar 8, 1961 , that (we) last saw the deceased alive on Mar 8, 1961 , and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE David R. Brewer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/10/61	
22c. PHYSICIAN'S NAME (Type) David R. Brewer				22d. ADDRESS Clear Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3.11.61		23c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery Rural Hancock Washington		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard F. Gurne				ADDRESS Hancock Md.		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



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FOR STATE
HEALTH DEPT.

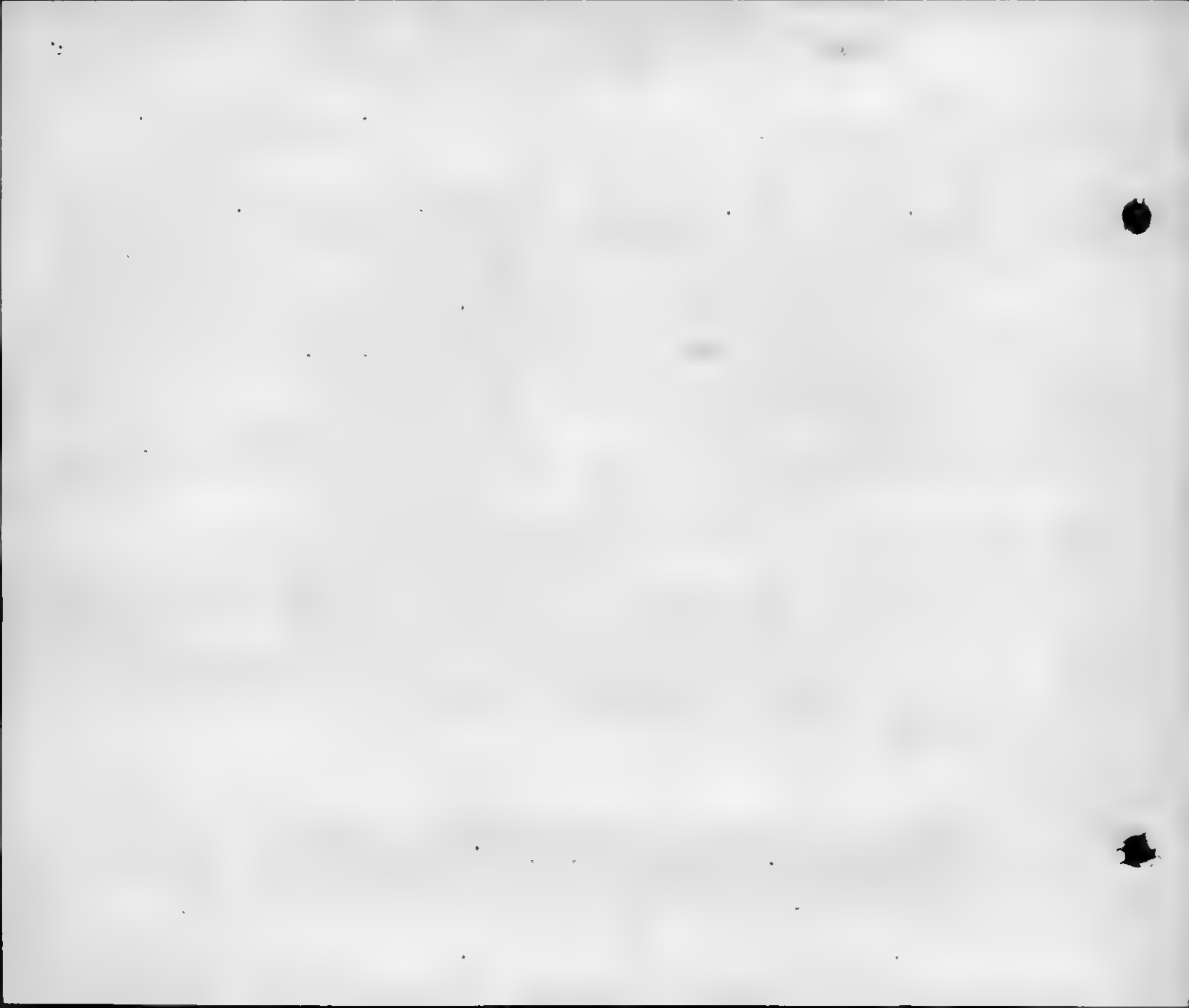
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G204 4/14/68 --1wk

03664

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md.		b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN Ia 80 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 W. Wilson Blvd.		d. STREET ADDRESS 301 W. Wilson Blvd.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First William		Middle Wellinger	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 9, 1880		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. DATE OF DEATH March 28, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gang leader		10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Jacob Wellinger		14. MOTHER'S MAIDEN NAME Mary Baur		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Karl Wellinger, Alexander, Va.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4/10/61 DUE TO (b) Arteriosclerosis - generalized and DUE TO (c) arteriosclerotic heart disease 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Prostatic hypertrophy -	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-30-61	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) Hagerstown, Md.		22e. DATE SIGNED 3/29/61	
23. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		23a. ADDRESS Hagerstown, Md.		23b. REGISTRAR'S SIGNATURE Arthur L. Krause	



may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3670

CERTIFICATE OF DEATH

03665

Item 23b, Film 4204 4/16/61 JWG

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Greencastle</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 72x-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>1307 N. Carlisle St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Blanche</u> Last <u>White</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 1865</u>
9. AGE (In years lost birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Greencastle, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Edward David Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Lucinda Reid</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Samuel Hunter</u> Address <u>915 Orchard Hill Road, Roanoke, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Bronchial Pneumonia</u> DUE TO (b) <u>Tenintion</u> DUE TO (c) <u>Arteriosclerosis - Gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>6 mo.</u> <u>5 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mer 12 1960</u> to <u>Mar 30 1961</u> , that (I) (last saw the deceased alive on <u>Mar 30 1961</u> and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		22b. DATE SIGNED <u>4-2-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>April 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Quinn</u> ADDRESS <u>Greencastle Pa</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Plank</u>	

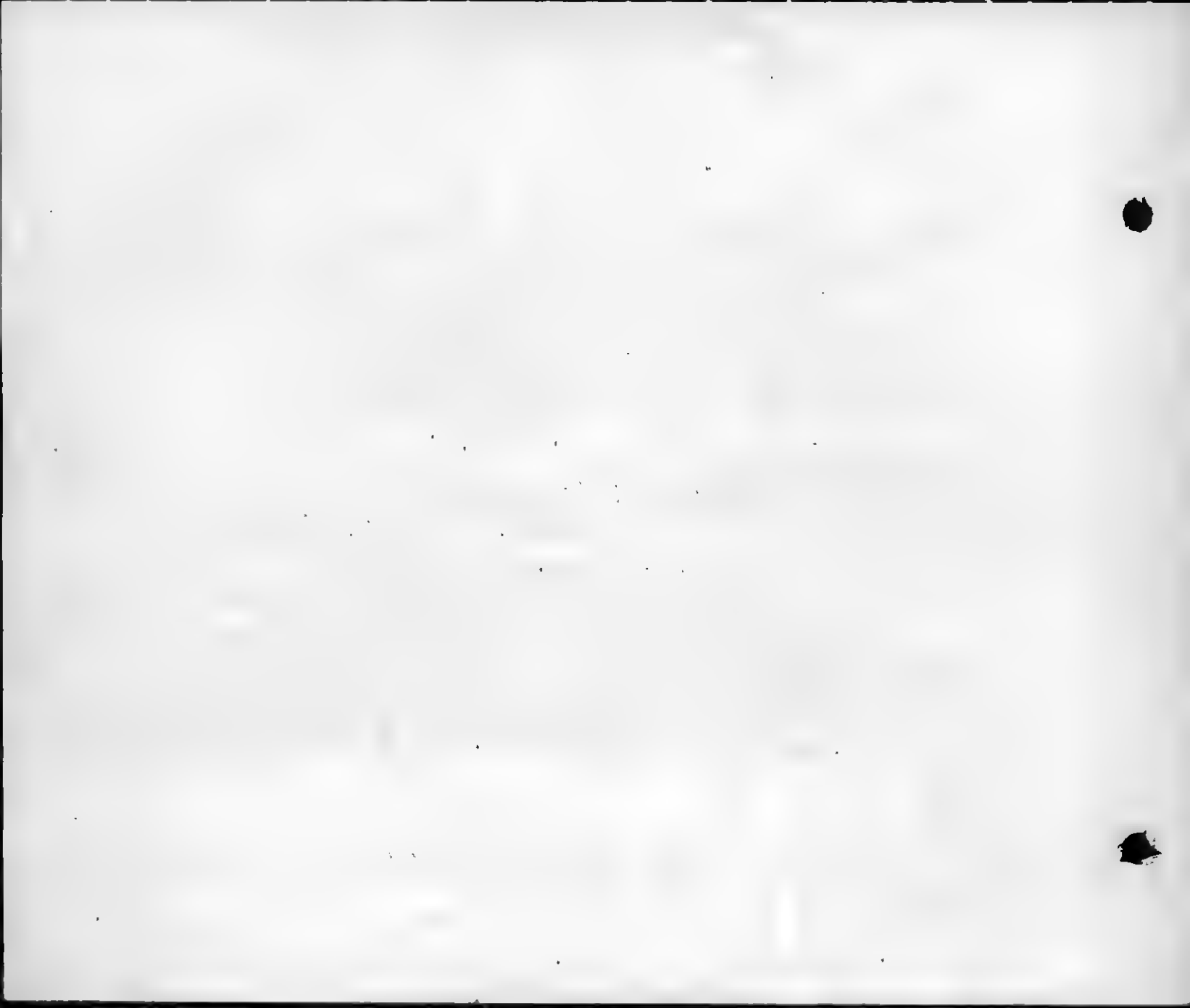
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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 3671
 CERTIFICATE OF DEATH

03666

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R#1</u>				c. LENGTH OF STAY IN 1b <u>20 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Day Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LARY GENEVIEVE WILEY</u>				4. DATE OF DEATH Month Day Year <u>March 4 1961 19</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1 1887</u>	
9 AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Sanford Sease</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Harry W. Wiley Day Road Hagerstown Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertension + Arteriosclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>vascular disease</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr +</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3 Mar</u> 19 <u>61</u> to <u>4 Mar</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>3 Mar</u> 19 <u>61</u> , and that death occurred at <u>1300</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>F. F. Lusby</u>				22b. PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>		22c. DATE SIGNED <u>4 Mar 61</u>	
22d. ADDRESS <u>230N Potomac St Hagerstown Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	



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3672
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03667

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 11 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Nursing Home				e. STREET ADDRESS 1821 Heisterboro Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle Braddon Last Wilson				4. DATE OF DEATH Month March Day 1 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1882	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Youngstown, Ohio				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry Braddon				14. MOTHER'S MAIDEN NAME Grute			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Charles R. Wilson				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestion heart failure & pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/27/61 19 to 3/1/61 19, that (I) (we) last saw the deceased alive on 2/28/61 19, and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.				22b. DATE SIGNED 3/2/61			
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR Hagerstown, Md.			
25b. REGISTRAR'S SIGNATURE Arthur S. Finner				25c. DATE MAR 6 '61			

WIDE IN

CONCEALMENT

THE MILLER & WATSON

1875

RECORD OF DEATH

1875

3673

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03668

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY VERNON YOUNG</u>				4. DATE OF DEATH Month Day Year <u>MARCH -16- 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY, 9-1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER - GENERAL BUILDING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NR. MIDDLETOWN</u>		11. BIRTHPLACE (State or foreign country) <u>FRED. CO. M.D.U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JONAS S. YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>ANNA SOPHIA SIGLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>216-07-7120</u>		17. INFORMANT <u>ROSCOE YOUNG</u> Address <u>4234 CAROWELL AVE BALTIMORE 6, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 42010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>10-14 yrs.</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> 19 <u>55</u> to <u>3/17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Kenneth C. Henson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth C. Henson</u>				22d. ADDRESS <u>Middletown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

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